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WELFARE in REVIEW

May-June 1972
volume 10—number 3

The Multiservice Neighborhood Center

Challenge and Response
Organizational Structure and Issues

Assessing Service Delivery Methods

Drug Utilization Review

U.S.
DEPARTMENT
OF HEALTH,
EDUCATION,
AND WELFARE

Social
and
Rehabilitation
Service

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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Published bimonthly by the Office of the Administrator, Social and Rehabilitation Service.

Use of funds for printing was approved by the Bureau of the Budget, April 17, 1969. Contents not copyrighted.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price $1.75 a year; $2.25 for foreign mailing; single copy, 35 cents.

An end and a beginning . . .

Welfare in Review will not be published beyond this issue, giving way to a new periodical. In the 10 years of the journal's history (July 1963—May-June 1972), its contributors have represented many fields. Sociology, social welfare, psychology, rehabilitation, economics, medicine, education, and history come particularly to mind. At first, as a voice for the old Welfare Administration, it was largely concerned with such social welfare issues as who receives public assistance, the employability of AFDC mothers and fathers, and the effects of public assistance on children. With the creation of the Social and Rehabilitation Service several years ago, its scope was broadened to include the findings and implications of research in rehabilitation for the mentally retarded and emotionally disturbed, the delivery of health services, the multipurpose neighborhood centers, and protective services for elderly persons—to give a few illustrations. In broadening its scope, *Welfare in Review* pointed up the implications of research for a wide spectrum of human services of concern to policymakers, program administrators, field practitioners, and researchers.

SRS is launching a new monthly periodical, *Human Needs.* The inside back cover of this issue of *Welfare in Review* has details. Though *Human Needs'* subjects will cover the spectrum of SRS programs, the new magazine will include reports on significant research findings and projects, emphasizing research utilization.

The change of course does not mean any lessening of SRS interest in research or in disseminating the results of research. Subscribers can rest assured that we will continue to make research results available in the new magazine and other communications.

JOHN D. TWINAME

The Multiservice Neighborhood Center

I. Neighborhood Challenge And Center Response

Edward J. O'Donnell and Otto M. Reid

Results from a preliminary analysis of the findings of the National Study of Multi-Service Neighborhood Centers were made available in 1971 through *Welfare in Review*. The larger project is a program of studies undertaken by the Division of Intramural Research; Social and Rehabilitation Service (SRS); U.S. Department of Health, Education, and Welfare; looking into the organization, integration, and delivery of social services at neighborhood centers. The portions previously reported on are an Inventory of a 1,000 neighborhood centers[1] and a study of the extent to which programs supported by SRS have been decentralized into neighborhood centers.[2] Here, in a two-part article, we report on selected portions of a personal interview with a national sample of administrators of 241 multiservice neighborhood centers and on replies to a mailed interview supplement returned by 192 of the 241 administrators. Part I reports on findings about the extent to which centers are meeting the challenges their neighborhoods pose. Part II reports on the organizational structure and staffing of centers and on a review of selected issues.

The present data from the National Study provide us with an opportunity to examine the extent to which centers are addressing the problems posed by their neighborhoods. They do not, however, make it possible to say how effective such attempts are.

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Neighborhood problems

To determine the kinds of problems neighborhood service centers face, the administrators were read a list of 20 problems and asked to rate each as *very serious*, *somewhat serious*, or *not so serious*. Table 1 presents data on their replies. They were also asked to identify any other problems they regarded as *very serious*. Voluntary observations are reflected in the discussion of replies.

Specifically, table 1 shows that center administrators see unemployment and poor housing conditions as the most serious problems facing the neighborhoods they serve—and blame landlords for at least part of the problem of inadequate housing. They see the use of drugs and narcotics as one of the most serious as well as one of the most prevalent problems. Generally, they do not regard crime and delinquency and, still less, insufficient police protection and the abuse of citizens by police as nearly so serious as unemployment or poor housing. They see stealing and vandalism as more pervasive than serious. Though they call into question the adequacy of the institutions that serve people—the school system, legal and health agencies, the police, the sanitation department, other municipal agencies—except for recreation facilities they do not see these institutions as seriously deficient. They seem to interpret educational problems more as a failure of the

student himself than of the school; criminal behavior more as a failure of the criminal than of the police or of other social institutions—unless, of course, they are interpreting deficient recreational facilities as contributing to criminal or delinquent behavior.

The administrators regard neither widespread discrimination nor the problems created by the business practices of local merchants as serious. But they are concerned about the apathy of neighborhood residents, not only in itself but also to the extent that they believe that still other problems might be more effectively dealt with—at least made less serious—if only residents were more involved and perhaps more willing to commit themselves to changing their environment. Again, however, administrators locate the cause of the problem more within the person than within the social structure. Most administrators did not spontaneously cite other very serious problems. When they did, inadequate transportation, unemployment among young people, and racial and ethnic tension are mentioned most frequently.

The administrators were also asked to choose from the problems they consider *very serious* the three they consider the most serious. Replies closely parallel data presented in table 1: unemployment and poor housing are regarded as the most serious, followed by the use of drugs and narcotics, the high number of school dropouts, and inadequate recreational facilities. Problems of poor school systems and inadequate health services are ranked higher than in the original ranking, and the problem of landlords with questionable practices is ranked considerably lower.

Specific objectives

We now turn to the objectives that centers set for themselves and the extent to which the administrators believe their centers have accomplished them. From a list of 13 conceivable objectives, as table 2 shows, more than half the administrators report that nine receive "great emphasis" at their centers and more than 80 percent report that each receives "some" emphasis.

Table 2 also indicates that most centers try to help people help themselves and beyond this provide personal services that may not be otherwise available. Generally, centers concentrate on clients' personal problems: fewer stress solving social-organizational problems than stress solving personal problems. Though a large number of administrators identify widespread unemployment as one of the most serious problems, surprisingly few place great emphasis on increasing the earning power and potential of neighborhood residents. Most, however, do place some emphasis on this activity.

Among the specific objectives receiving little or no emphasis are such efforts as encouraging a militant approach to the solution of social problems, increasing the political power of neighborhood residents, and creating or stimulating a sense of dissatisfaction with living conditions. Clearly, conflict-oriented social and political action is not a major objective of most of the neighborhood service centers. The administrators apparently see such efforts as ineffective—or, if effective, not worth the risk entailed—or they may just be unwilling to stir up trouble or rock the boat.

Again, in view of the near consensus about the seriousness of poor housing and widespread unemployment, the fact that close to a fifth of all administrators report little or no emphasis in their programs on improving the housing and physical characteristics of the neighborhood nor on increasing the earning power and potential of neighborhood residents is perhaps surprising.

Programs

It was assumed that resident and neighborhood needs might be met through one or a combination of means: the provision of *information* about and *referral* to other agencies; the provision of direct services; the modification of the policies and practices of community agencies and institutions—that is, *social advocacy;* and the organization and mobilization of neighborhood residents—that is, *social action.*

Table 3 presents data on the major means the centers use, as reported by the administrators. As it shows, nearly three-quarters (73 percent) of the centers place great emphasis on information and referral, two-thirds (68 percent) on the provision of direct services, and fewer than half on social action (47 percent) and social advocacy (41 percent). Again, consistent with data presented in table 2, administrators report emphasizing person-oriented services more than efforts to change the social-organizational milieu.

Services provided by the center. The most detailed and least analytic expression of center objectives lies in the breakdown of the specific services they directly provide, which are often the primary means by which they try to achieve their objectives. For the most part, other

Table 1. Neighborhood problems identified as serious by center administrators

Problems	Percent identified as –	
	Very serious	Very and somewhat serious
Poor housing conditions	57.7	86.7
Widespread unemployment	57.7	85.5
Use of drugs and narcotics	48.1	86.7
High number of school dropouts	48.1	83.4
Inadequate recreational facilities	47.7	79.2
Apathetic residents	41.1	83.4
Landlords with questionable practices	39.4	78.0
Stealing and vandalism	39.0	81.3
Poor school system	32.0	66.4
Inadequate health services	31.5	68.4
Insufficient legal services	28.2	63.9
Insufficient police protection	27.0	64.3
Poor sanitation service	27.0	61.4
The presence of hoodlums or other undesirable persons	21.6	67.2
Purse-snatching and mugging	20.7	46.8
Widespread discrimination	19.9	59.7
Unresponsive municipal agencies	19.1	66.8
Merchants with questionable business practices	14.5	49.8
Police harassment	10.0	42.0

objectives are met through referral to other agencies that are presumably better equipped to deal with client problems. Table 4 presents a detailed breakdown of the types of services centers directly provide. Counseling services are provided by more than eight of every 10 (82 percent). Educational and recreational services are provided by about seven in 10, and unemployment and welfare services by close to six in 10. All other designated services are provided by fewer than half.[3]

Social action activities provided by the center. Other center activities are directed at the community or the broader social and cultural milieu in which people live as the source of client problems. As table 5 indicates, some three of every four centers (76 percent) engage in community planning, more than half (54 percent) in neighborhood development, and four in 10 (42 percent) in social change activities. About six in 10 coordinate existing services (63 percent) and plan new services (59 percent), and nearly half (47 percent) are helping modify the policies and practices of other community agencies. Some three in 10 conduct clean-up campaigns (34 percent), organize tenant councils (28 percent), and conduct voter registration drives (28 percent) in their neighborhoods.

Table 2. Specific objectives receiving emphasis at the center

Objectives	Percent receiving–	
	Great emphasis	Some or great emphasis
Helping people to cope more effectively with their own problems	79.7	97.1
Helping people become more knowledgeable about neighborhood and community services	75.5	96.2
Increasing the sense of pride and self-esteem in neighborhood residents	75.1	94.6
Encouraging people to participate in organizations that try to improve conditions	71.8	94.2
Increasing the sense of belonging to the neighborhood	69.7	90.4
Solving the personal problems that people bring to the center	68.5	97.1
Coordinating the work of community agencies to better serve the particular needs of the neighborhood	63.5	91.7
Improving the quality and reliability of public services	53.1	87.5
Increasing the earning power and potential of neighborhood residents	53.1	81.7
Improving the housing and physical characteristics of the neighborhood	46.5	78.5
Creating or stimulating, where appropriate, a sense of dissatisfaction with living conditions	38.2	74.7
Increasing the political power of neighborhood residents	24.9	59.8
Encouraging a militant approach to the solution of social problems	5.8	27.0

Challenge and response compared

How well do the administrators' assessments of neighborhood problems mesh with their perception of center objectives and the means they pursue to attain them? One of the analytic methods the study used was to classify all problems, objectives, and means by whether they were addressed to personal or social-cultural issues.

Table 6 presents data on the problems, objectives, and means identified and adopted by multiservice neighborhood centers and the extent to which they focus on personal as opposed to social-organizational aspects.

The following outline shows the ways in which the problems, objectives, and means were classified for analysis:

	Personal	Social-organizational
Problems:	Use of drugs and narcotics	Poor school system
	Apathetic residents	Widespread unemployment
Objectives:	Solving the personal problems that people bring to the center	Improving the housing and physical characteristics of the neighborhood
	Increasing the sense of pride and self-esteem in neighborhood residents	Coordinating the work of community agencies to better serve the particular needs of the neighborhood
Means:	Information and referral	Social action
	Direct services	Social advocacy

Some problems, objectives, and means fit more snugly than others into these boxes. For example, drug users and high school dropouts may well be victims of ghetto conditions and inadequate schools, but such problems are classified here as personal because they focus on the individual drug user and school dropout. The objective of encouraging people to participate in organizations that try to improve conditions is classified as social-organizational because their primary objective is to improve conditions through resident participation. Of course, some centers are just as likely to regard participation as a worthy end in itself and might consider such an objective as personal. Finally, there are some social action or advocacy activities that might well be more concerned with helping particular persons. Nevertheless, in this analysis, all direct service and information and referral activities are classified as personal and all social action and social advocacy activities as social-organizational.

The most general finding shown in table 6 is this:

Table 3. Major means centers emphasize

Means	Percent receiving—	
	Great emphasis	Great or some emphasis
Information and referral	73.4	95.6
Direct services	67.6	92.9
Social action	47.3	78.9
Social advocacy	40.7	73.4
Total	241	

Table 4. The direct services multiservice neighborhood centers provide

Type of service	Percent of centers
Counseling	82.3
Personal counseling	78.6
Family counseling	63.5
Group counseling	54.7
Other counseling	3.6
Education	72.4
Adult classes	48.4
Preschool program	43.8
Cultural courses	31.8
Other education	8.9
Tutoring	8.3
Homemaking classes	4.2
Typing and vocational courses	2.1
Recreation	69.3
Crafts	53.1
Athletics	51.0
Arts	48.4
Dances	44.3
Hobby groups	33.9
Group programs	10.9
Recreation unspecified	8.9
Other recreation	3.1
Employment	62.0
Job placement	52.1
Job training	27.6
Other employment	9.9
Welfare	55.2
Emergency aid	44.3
Food stamp program	19.3
Other welfare	5.7
Surplus food commodities	3.1
Health	43.8
Family planning services	25.5
Immunizations-innoculations	17.7
Mental health services	17.2
Physical examinations	15.1
Nursing services	14.6
Diagnostic services	9.9
Dental services	8.9
Other health	6.3
Housing	43.2
Listing and locating	33.3
Housing improvements	19.8
Cooperative sponsorship	13.5
Other housing	5.2
Services to the elderly	40.6
Recreation	16.7
Home care	9.9
Other services	9.9
Protective services	7.8
Meals on wheels	5.7
Transportation	2.6
Legal	32.3
Legal aid	22.4
Probation services	11.5
Parole services	6.8
Other legal	4.7
Public assistance	26.0
Public assistance eligibility determination	21.9
Other public assistance	5.7

Type of service	Percent of centers	
Day care		23.4
Consumer services		21.9
Credit unions	14.1	
Buyers clubs	9.4	
Consumer guidance	4.7	
Medical eligibility determination		18.8
Vocational rehabilitation		14.6
Child welfare		11.5
Foster home findings and placement	7.3	
Protective services	4.7	
Adoption services	3.6	
Other child welfare	2.1	
Other services		7.3
Base	192	

though roughly comparable proportions of administrators regard both personal and social-organizational problems, on the average, as *very serious*, the centers usually develop personal objectives and adopt personal means much more frequently than they do social-organizational objectives and means. Moreover, to the extent that estimates can be made of the proportion of center time given to one or the other major means, on the average, centers spend close to 70 percent of their time pursuing methods that deal with personal issues and just over 30 percent of their time pursuing methods that deal with social-organizational aspects of issues.

Table 5. The social action services multiservice neighborhood centers provide

Type of social action	Percent of centers	
Community planning		76.0
Coordinating existing services	62.5	
Planning new services	59.4	
Modifying agency policies and practices	46.9	
Planning special projects	7.3	
Other community planning	11.9	
Neighborhood development		53.6
Conducting cleanup campaigns	34.4	
Organizing tenants councils	28.1	
Organizing buyers clubs	13.0	
Organizing self-help programs	10.4	
General neighborhood improvement	4.7	
Other neighborhood development	7.8	
Social change		42.2
Voter registration drives	28.1	
Conducting protest demonstrations	12.5	
Organizing social action groups	4.7	
Other social change	14.5	

Table 6. Problems identified and objectives and means adopted by multiservice neighborhood centers, by personal and social organizational focus

Aspects	Percent classified as—	
	Personal	Social-organizational
Problems (regarded as very serious)	36.4	31.6
Objectives (receiving great emphasis)	70.3	43.4
Means		
(receiving great emphasis)	70.5	44.0
(total time allocated)	67.5	32.5
(response to very serious problems)	71.0	29.0

From a preliminary assessment of the extent to which specific problems identified as very serious by center administrators are met by providing one or another service or activity, we found that eight problems were identified as *very serious* by at least four of every 10 administrators.

As table 7 shows, there is no ready fit between the problems identified as *very serious* and the solutions provided by the centers. Of all of the problems identified by 40 percent or more of the administrators as *very serious*, inadequate recreational facilities are specifically dealt with by seven in 10 centers, unemployment by six in 10, and resident apathy by just over half.

Fewer than three in 10 centers are in a position to handle the problem of landlords with questionable practices or the problem of poor housing, and though legal services may address some of these issues, most legal services are probably related to problems other than housing. Fewer than one in 10 centers deals with the high number of school dropouts, and none seem able to specifically handle the problems of drug abuse and stealing and vandalism—at least to the extent that any special services or activities are identified. This finding is surprising because the administrators identify the problem of drug abuse as the third most serious problem in their neighborhoods, close behind the problems of inadequate housing and unemployment. It is possible, however, that the whole range of counseling services provided by more than eight of every 10

Table 7. Some very serious problems and percent of centers providing services or activities addressed to them

Problems	Related services or activities	Percent of centers providing such services or activities
Inadequate recreational facilities	Recreation services	69.3
	Organizing recreation programs	2.1
Widespread unemployment	Employment services	62.0
Apathetic residents	Neighborhood development	53.6
Landlords with questionable practices	Organizing tenant councils	28.1
	Legal aid	22.4
Poor housing conditions	Housing improvements	19.8
	Organizing housing programs	4.2
High number of school dropouts	Tutoring	8.3
Use of drugs and narcotics[1]	--	--
Stealing and vandalism[1]	--	--

[1] *Though there were no specifically designed services or activities identified in relation to these problems, this is not to say that they are not being dealt with in some way by the centers.*

centers as well as the more specialized mental health, probation, and parole services are potentially available to deal with the drug problem and other problems as well. Indeed, a case might be made for the contribution of recreational services toward the alleviation of the drug problem or stealing and vandalism. And this is not to deny the potential therapeutic value of counseling and recreational services. Nevertheless, the fact remains that some very serious problems are not specifically dealt with by the centers.

Problems such as poor school systems, inadequate health services, and insufficient legal services are identified as very serious by three of every 10 administrators. Just over four in 10 (44 percent) provide health services, and just over a fifth (22 percent) offer legal aid services, through only 2.6 percent try to improve the schools. Again, these data point up the fact that in many cases relatively few programs are geared to the particular problems that center administrators identify as *very serious* in their neighborhoods.

Outcomes as perceived by the administrators

Only one question was directed toward determining how successful centers are in their efforts to help cope with problems of the neighborhood or of its residents. Though this single question cannot be regarded as a true indication of the success of the centers, it does provide some imperfect indication of how successful administrators think they are.

After the administrators indicated the three neighborhood problems they regarded as most serious, they were asked to judge how successful their center was in dealing with these problems. As table 8 shows, for the 601 problems identified by administrators as one of the three most important neighborhood problems, one in seven (15 percent) administrators indicates that his center does not even try to work on the problem; and more than one in five others indicate that their centers are not very successful in dealing with the problem. For only one in eight problems (13 percent) does the administrator believe that his center is very successful in dealing with the problem.

Major conclusions and implications

The major conclusions and implications of this part of the national study—the services that multipurpose neighborhood centers offer to meet their neighborhood's problems, as reported by their administrators—are these:

—There is no ready fit between the neighborhood problems identified by administrators as *very serious* and the activities centers engage in. Among the problems identified, those of inadequate recreational facilities and widespread unemploy-

Table 8. The center's success in dealing with one of three most serious problems

Degree of success	Percent of centers
Very successful	13.1
Somewhat successful	49.1
Not very successful	22.1
Did not even work on problem	14.6
	601 = Total number of problems

ment are perhaps most frequently addressed—but by no more than six or seven of every 10 centers. Housing problems, school dropout problems, and drug abuse—also identified as very serious—apparently are not being addressed. And though the "softer" services—counseling, education, recreation—doubtlessly help alleviate problems in general, serious problems remain for which particular programs have yet to be designed.

-Centers deal successfully with some but not with all the problems identified. For more than one of every 10 problems identified as very serious, administrators say they don't even attempt to deal with them. Of those that they do try to work on, administrators report little or no success with nearly a fourth. Altogether, then, the centers have not yet found a way to effectively deal with more than a third of the very serious problems in their neighborhoods.

-Perhaps the most outstanding finding is the incongruence between the way administrators define problems and the way their centers try to handle these problems. First, there is much less disposition to see problems as social problems than current conceptual analysis would warrant. Further, the data suggest that even when the administrator views problems as primarily social, organizational, or institutional, center activities still most often focus on the person—on trying to change him or at least deal with *his* problems. Our expectation was that the centers would be trying harder to reform deficient institutions, to improve the people-serving capacities of communities, to design more effective social networks. But perhaps this is too much to expect. Perhaps there is good reason for neighborhood centers and social service agencies to pursue person-oriented methods, even while recognizing the basically social character of the problems. After all, it is not institutions that confront social service agencies and workers with problems—it is people. And even when the problem each presents resides mainly in the social system rather than in themselves, individual clients need immediate help. The agency cannot tell an unemployed man that it is the fault of his community or Nation that he has no job. It cannot ask him to be patient while one works on and improves the economic system. The agency cannot ask a mother to wait until changes in educational methods make school more interesting for her unmotivated and truant child. So we cannot fault centers for focusing on problems as individual problems, even while we might like to see them place more stress on solving social problems and on reforming and improving institutions, communities, and social systems.

-By the same token, we cannot remain complacent. We cannot rationalize the kind of help we give to persons merely because they are there or because it is convenient or that is all we know how to do. We can tolerate this no less than we can tolerate tinkering with some "system" just because tinkering happens to be fashionable. The obvious challenge is to determine which conditions are best dealt with and by which methods and under which circumstances. This means examining problems in a context that allows for choosing among alternative ways of meeting such problems—and then moving from positions of knowledge and strength. So that if we should decide to work on a given problem in a certain way, it will be because we have made a considered and self-conscious decision to do so and not because this is the way we've always done it or because it's the "thing to do." And we will have made a little progress in the process—maybe not much but some.

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[1] *Edward J. O'Donnell and Otto M. Reid, "The Multiservice Neighborhood Center: Preliminary Findings From A National Survey,"* Welfare in Review, *May-June 1971, pp. 1-8.*

[2] *Edward J. O'Donnell, "Service Integration: The Public Welfare Agency and the Multiservice Neighborhood Center,"* Welfare in Review, *July-Aug. 1971, pp. 7-15.*

[3] *The earlier and shorter Inventory questionnaire, addressed to 969 administrators of such multiservice neighborhood centers, had asked whether any of a shorter list of 14 more broadly defined direct services were offered by the centers. The results from both mailed questionnaires, conducted some 18 months apart, show remarkably comparable figures. Percentages reported for counseling, education, recreation, employment, health, services to the elderly, and eligibility determination for public assistance and medical assistance varied by less than 5 points; percentages for housing, legal, and consumer services varied by less than 10. See Edward J. O'Donnell and Otto M. Reid, "The Multiservice Neighborhood Center: Preliminary Findings From A National Survey,"* Welfare in Review, *May-June 1971, pp. 1-8.*

A third comparison, however, brought discrepant results. In the questionnaire administered in person to the administrator, he was asked, in different wording, which of a shorter list of services his center provided. Where the services referred to duplicated those listed in either the Inventory or the later mail questionnaire, the number of centers reporting offering these services tended to be higher by 10 to 15 percent of centers. The discrepancy may be attributed either to wording changes that may have resulted in less restrictive interpretation of whether services were offered in the personal interview phrasing, in the greater deliberation involved in the mailed interview techniques, or in the lower representation of large urban areas in the second mail questionnaire.

II. Organizational Structure And Selected Issues

Many questions were explored with the administrators, both during the face-to-face interview and in the mail questionnaire, for the purpose of developing additional data on the structure and functioning of the centers and probing issues that would be of interest to program planners and policymakers. The central issues of the report are summarized below:

The center's organizational structure and climate—including policymaking boards, advisory committees, and staffing patterns.

The number and kinds of professional workers represented in the center—including outstationed workers (persons assigned from other agencies to a center)—participating community agencies, and the use of volunteers.

The core services—including the availability of transportation, case coordination, service integration, and center communication and publicity.

The characteristics, orientation, and philosophy of center administrators.

Program dilemmas and selected issues in the organization, delivery, and staffing of centers.

The administrator's autonomy and the center's decisionmaking powers.

Center reference groups and administrator satisfaction.

Organizational structure and climate

Most of the centers, some six of 10 (61 percent), have only two staff levels, the administrator and the worker. Close to three in 10 (29 percent) have a three-level staff—a supervisory level is inserted between the worker and the administrator. About a 10th (9.5 percent) have a four-tier system—two distinct supervisory levels exist between the worker and the administrator.

Neighborhood centers have a reputation for being casual and informal—for eschewing the more formal trappings attributed to traditional social agencies. To determine whether the reputation is deserved, the study sought to describe the organizational climate of the centers by asking administrators the extent to which certain organizational features apply to their centers. Selected aspects of organizational conformity, clarity, and congeniality were tapped and compared to data collected previously on departments of public welfare.[1]

Though center administrators think that their workers stick pretty close to rules and regulations, they also think that such rules are kept to a minimum in their centers and that by far the more important consideration is that a worker do a good job. In their opinion most policies and procedures are clearly defined and well-structured and congeniality and friendliness prevail among staff members.

Table 1 permits a comparsion of the perceptions that administrators have of their centers on the one hand and those that directors of departments of public welfare have of their agencies on the other. Not surprisingly, public welfare agencies are much more implicated in rules, regulations, and formal procedures and are more concerned than centers with formal organization and authority—even if their workers are doing a good job. Interestingly enough, however, the effectiveness of public welfare departments is also somewhat more likely to suffer from insufficient organization and planning. Though nearly a 10th (8.8 percent) of the center administrators believe that their staff workers are cool and aloof toward each other, none of the public welfare directors do. And though 10 percent of the welfare directors believe that their workers lack loyalty to the agency, only 4 percent of center administrators hold such a belief.

Nearly half (47 percent) the centers have both a policymaking board and an advisory committee and only 5 percent have neither. More than a fifth (22 percent), however, do not have a policymaking board but function only with an advisory committee or with neither. A comparison of the committee structure of

[1] *Edward J. O'Donnell and Otto M. Reid, "The Multiservice Neighborhood Center: Preliminary Findings from a National Survey,"* Welfare in Review, *May-June 1971, pp. 1-8; Edward J. O'Donnell, "Service Integration: The Public Welfare Agency and the Multiservice Neighborhood Center,"* Welfare in Review, *July-Aug. 1971, pp. 7-15.*

Table 1. Selected organizational characteristics of multiservice neighborhood centers and public welfare departments

Characteristics	Percent	
	Centers	Departments of public welfare
Conformity		
Ordinarily workers at the center (agency) stick pretty close to standard policies and procedures	94.6	100.00
Formal procedures are kept to a minimum in the center	86.7	54.9
The center is not particularly concerned about organization and authority as long as workers do a good job	80.9	62.8
There tends to be a lot of rules, policies, procedures, and standard practices that workers have to learn	43.6	97.3
Clarity		
Workers seem to feel they are members of a well-functioning staff	95.8	94.1
Policies and structure of the center have been clearly explained to the workers	94.6	95.5
Worker assignments tend to be clearly defined and logically structured	88.0	93.5
Center effectiveness sometimes suffers from insufficient organization and planning	40.2	50.3
Congeniality		
A friendly atmosphere prevails among the workers at the center	98.3	100.0
Generally, people seem to be proud to work in the center	96.3	96.7
Staff workers tend to be cool and aloof toward each other	8.8	0.0
Workers don't seem to feel very much personal loyalty to the center	4.1	9.9
Base	241	154

centers with an earlier HEW study of local departments of public welfare is instructive. The public welfare departments had reported that some 36 percent of such agencies have a board only, 20 percent have a committee only, 19 percent have both, and 24 percent have neither. Thus, though relatively few centers operate without a board or committee, as many as a fourth of the public welfare agencies do. And though nearly a half of the centers have both boards and committee, only a fifth of the public welfare agencies do.

Table 2 summarizes the administrators' replies to questions about the attributes they find desirable or undesirable in board members. After the relative value they attach to these attributes was determined, the administrators were asked which they consider the most valuable. As table 2 indicates, fully three-quarters (75 percent) consider an interest in the center's program as one of the three most valuable assets of a board member. They also value highly ability to listen, learn, speak up, and make views known. Whether these relatively different attributes are rated differently by different kinds of administrators will be determined in subsequent analysis. Board member income, however—whether high or low—is of little or no apparent interest to administrators. In fact, more than four in 10 said that the ability to contribute money to the center (43 percent) and an income below the poverty level (42 percent) are distinctly not valuable for a board member, and nearly a fifth (18 percent) consider living in the neighborhood not valuable at all.

Staffing patterns

As of January 1970, more than nine of every 10 centers were employing full-time workers on their staffs; just over six in 10 (64 percent) were employing staff workers part time. More than a third were employing between one and four (35 percent) or 10 or more (34 percent) full-time equivalent staff workers, and just over a fourth (26 percent) were employing between five and nine. Proportionately more full-time than part-time workers were employed, regardless of staff size; but where part-time workers were employed at all, they were most likely to be found on the staffs of the smaller centers.

Three of every four centers (76 percent) were employing at least one full-time professional worker and three of every 10 (30 percent) at least one part-time professional worker. Two-thirds (67 percent) were employing at least one semiprofessional worker full time and four in 10 (39 percent) at least one part-time. Professional workers are employed full time proportionately more often than semiprofessional workers and semiprofessional workers are employed part time proportionately more often than professional workers. In general, centers are most likely to employ full-time professional staff workers and least likely to employ part-time professional workers.

The paid professional and semiprofessional staff members employed in the centers are complemented in

their work by volunteers. Table 3 shows the distribution of the numbers of such volunteer workers in centers. Fully nine of every 10 centers report using volunteers. They vary widely in the number of volunteer workers they use, however, close to a fifth using between one and four and another fifth using as many as 50 or more. But neither the nature of such volunteer work nor the time that volunteers spend at the centers was determined.

Well over a third of the centers (37 percent) lost no staff members during the year and a like proportion lost at least 20 percent; in a relatively small number of centers (5.8 percent), the number of staff members lost that year was as high or higher than the total staff size at the beginning of the year. Where this condition obtained, all staff members employed at the beginning of the year may have left and been replaced during the year, but more likely some staff members remained while some positions became vacant several times during the year and were filled after each vacancy. Staff attrition represents only the number of employees leaving during the year as a proportion of all persons employed at the beginning of the year.

Nearly half the centers report no net increase in professional and semiprofessional staffs at the time of the study. Yet more than a quarter grew by 100 to 199 percent and a relatively small number by 200 percent or more.

Most administrators (62 percent) report having between one and three different professions or disciplines represented among their staffs. Close to a fifth (18 percent) have between four and six, and close to a 10th (8.9 percent) have none.

Table 4 shows that more than six in 10 centers have social workers, four in 10 have teachers, and three in 10 have employment counselors and nurses. Physicians, lawyers, and rehabilitation counselors are represented in fewer than a fifth of all centers. Other kinds of professional workers—psychologists, psychiatrists, dentists, public health educators, and researchers—are employed in fewer than a 10th.

As table 4 further indicates, with the exception of social workers and teachers, most centers employing professional workers employ only one.

Table 5 presents data on the number of professional workers employed by other agencies and outstationed at the neighborhood centers. Nearly half the centers have professional workers on loan from other community agencies and a quarter have five or more. At the time of the national Inventory, some 18 months earlier, only a third had such outstationed staff

Table 2. Selected attributes administrators consider most valuable in board members

Attribute	Percent most valuable
Interest in the center's program	75.1
Ability to listen and learn	49.8
Ability to speak up and make view known	40.2
Influence in the larger community	29.5
Influence in the neighborhood	19.1
Wide-ranging personal contacts	18.7
Living in center neighborhood	12.0
Knowledge of a technical field important to the activities of the center	11.2
Ability to contribute money to the center	8.3
Experience in health or social welfare activities	7.9
Being personable and friendly	7.5
Income below poverty level	5.0
Base	241

members. It is not known whether this increase is due to the time lapse between the studies, to sampling variations, or to a combination of both.

As table 6 shows, when community agencies place workers with neighborhood centers, fully six of every 10 provide only one professional worker, a fifth provide two, and close to 20 percent three or more. As indicated in table 7, health-related agencies comprise a fifth of the agencies that outstation professional workers with centers. Educational, employment, counseling, and legal agencies each comprise a 10th of all such community agencies, and welfare-related agencies represent some 7 percent of the total. The fifth that comprise agencies grouped in the "other" category represent a wide assortment of community agencies.

Center services

Center administrators were asked about the ways in which they provide for intake and the extent to which they have developed outreach activities and followup procedures.

For intake fully two-thirds (66 percent) report that center workers take turns seeing clients for the first time and usually follow through with such clients themselves, and nearly a fourth (23 percent) report that their centers have special intake workers—workers who see clients the first time they come to the center but who then refer them to other workers. The rest of the centers handle intake by some other means.

Table 3. Number of volunteers in multiservice neighborhood centers

Number of volunteers	Percent of centers
None	8.9
1-4	17.8
5-9	16.1
10-19	19.5
20-49	20.1
50 or more	18.4
Base	191

Table 4. Professions represented in multiservice neighborhood centers

Professions	Percent of centers having—			
	Any	1 only	2-4	5 or more
Social work	63.5	22.9	25.5	15.1
Teaching	42.2	14.6	16.1	11.5
Employment counseling	33.3	23.4	6.3	3.6
Nursing	30.2	21.9	5.7	2.6
Medicine	16.6	10.4	3.6	2.6
Law	16.1	13.5	2.1	.5
Rehabilitation counseling	13.0	12.0	1.0	--

Table 5. Paid professional workers outstationed at multiservice neighborhood centers

Number of professional workers	Percent of centers
None	51.6
1	7.9
2	6.8
3-4	8.4
5-6	6.8
7-9	6.8
10-19	7.9
20 or more	3.7
Base	190

Nearly nine of every 10 centers (88 percent) have an outreach program in which workers contact area residents in their homes to tell them about the center, but only four in 10 (43 percent) have special outreach workers who spend all their time in the neighborhood.

Again, close to nine of every 10 centers (86 percent) engage in followup activities in which workers followup clients who are referred to other agencies to make sure that they get the services they need; however, only 5.2 percent have special followup workers who spend all of their time at this task. In close to three-quarters (73 percent) of the centers, workers assume responsibility for followup with their clients and try to accomplish their objective by one or more of the procedures presented in table 8.

Administrators were also asked whether they *almost always, usually, sometimes, rarely,* or *never* arrange transportation for clients referred to other agencies. Three in 10 (29 percent) report that they almost always arrange such transportation. More than half (52 percent) report that they sometimes arrange such transportation, and nearly a fifth (18 percent) say that they rarely or never do.

In summary, most centers rotate intake among their workers, conduct outreach programs, and engage in followup activities. When it comes to procedures used in referrals to other agencies, most centers call the agency in question and arrange for the appointment—but are not always able to provide transportation for their clients.

As table 9 indicates, fully a third of the center staffs spend equal amounts of time in providing both individual and group services. Moreover, fewer than one in 10 centers reports providing either individual or group services exclusively.

Communication, coordination, integration, publicity

The formal means by which centers provide for interservice and interagency communication is particularly salient to the concept of the multiservice center and the capability of such centers to develop an integrated system of service delivery. Table 10 provides data on the percent of centers that employ various means for staff development, case coordination, service integration, and interagency communication.

As table 10 indicates, most centers hold general or executive staff meetings at least once a month. Case conferences—conferences in which specific client needs

Table 6. Distribution of professional staff members placed in multiservice neighborhood centers by community agencies

Professional staff members	Community agencies	Percent
1	177	61.7
2	56	19.5
3	19	6.6
4	14	4.9
5 or more	21	7.3
	278	

and problems are discussed—are held among center staff members only in half the centers, however, and by four in 10 where staff members from other agencies are involved. Indeed, about three of every 10 centers report holding *no* case conferences among center staff members and none involving staff members from other agencies.

A more detailed breakdown of the formal opportunities for case coordination and service integration, based on selected indicators, is shown in table 11.

Even with the opportunities made available for case coordination and service integration, there is no guarantee of success—indeed, such formal arrangement efforts to coordinate and integrate service for the client may fail. Yet it is clear that where there are no such formal arrangements, the chances for success are diminished further. And though some degree of coordination and integration may be achieved informally, such efforts are vulnerable to the personal bias of individual workers. Thus, in some three of every 10 centers, there is no formal opportunity for case coordination, and in at least one in 10 no formal opportunity for service integration.

Finally, administrators were asked about the ways in which centers publicize their services and make them known to the residents of the neighborhood and larger community. Table 12 reports on these responses.

Characteristics, orientation, and philosophy

Data on the personal and professional characteristics of the center administrators produce this profile: close to four in 10 (38 percent) have only a bachelor's degree, but nearly half (47 percent) had attended graduate school—29 percent have a master's degree and 1 percent doctorates. The fields in which they are most likely to hold their degrees are education (18

Table 7. Community agencies placing professional staff members in multiservice neighborhood centers, by type of agency

Type of agency	Percent of agencies	
Health		20.6
Public health	9.4	
Mental health	4.9	
Hospitals	3.5	
Planned parenthood	2.8	
Education		12.9
Colleges	5.6	
Schools	4.2	
Departments	3.1	
Employment		10.8
Counseling		10.5
Legal		9.4
Legal aid	6.3	
Corrections	3.1	
Welfare		7.3
Opportunity		3.8
Rehabilitation		2.8
Housing		2.4
Other		19.5
		287

Table 8. Followup procedures used by multiservice neighborhood centers

Procedures	Percent of centers
Call the agency and set up an appointment for the client	58.9
Write formal letters of referral to agencies for the client	30.7
Give the client information about the agency and assume he'll follow through himself	24.5
Provide direct transportation or go with the client	15.1
Call or contact the agency at some later time	13.0
	192

Table 9. The distribution of professional and semiprofessional staff time, by mode of service

Mode of service	Percent of centers	
Individual		29.7
Exclusively (100 percent)	6.8	
Mostly (51 to 99 percent)	22.9	
Individual and group equally		33.9
Group		22.4
Exclusively (100 percent)	6.3	
Mostly (51 to 99 percent)	16.1	

Table 10. Selected means of communication, coordination, and staff development in multiservice neighborhood centers

Means of communication	Percent of centers holding event–	
	At least monthly	Not at all
Staff meetings for both professional and semiprofessional employees	81.8	12.0
General meetings for all center employees	75.5	11.5
Executive staff meetings with supervisors	72.5	19.3
General meetings with representatives of other community agencies	56.3	14.6
Staff meetings for professional employees only	52.7	39.6
Case conferences among center staff members	52.6	27.1
Talks by center professional staff employees	47.9	33.3
Staff development and training sessions	44.8	24.0
Case conferences among center staff employees and staff employees from other agencies	40.7	32.3
Talks by outside speakers	39.5	27.6
Talks by center semiprofessional staff employees	37.5	46.9
Publication of newsletter for employees	31.2	60.9
Base	192	

percent), social work (17 percent), or one of the social sciences (14 percent). Some seven of 10 (70 percent) are men; over half (55 percent) are white, more than a third (35 percent) are Negro, and fewer than one in 10 (7.3 percent) are Spanish-American; and half (51 percent) are between 35 and 54 years old, more than a third (36 percent) are younger–under 35– and just 14 percent are 55 or older. Finally, more than half (55 percent) live in the neighborhood or the area the center serves.

A fifth of the administrators (20 percent) say it is *very important* for the center's professional staff members to live in the neighborhood or area served by the center. A third (34 percent) say that it is *somewhat important,* but more than four in 10 (43 percent) say that it is *not very important* (though, as pointed out, more than half the administrators live in the areas their centers serve!).

Fully eight of 10 (81 percent) of the administrators report having a particular point of view about their center's approach to its work in the neighborhood or community. Table 13 indicates that administrators have many different views on this subject. The predominant view sees a close relationship between a community and a center that is responsive to the needs of area residents. The difference between this view and the view held by a much smaller number of administrators–namely, that the center should belong to the people–is, perhaps, subtle but nevertheless substantial. In the first view administrators retain control of center operations; in the second residents are regularly involved in, even if they are not actually in control of, center activities. Other views rest on still other ideas administrators have about centers: that a center should strive to help people become more self-sufficient; that it should, to a lesser extent, be imaginative in its use of community resources; that it should be family-oriented; and that it should bring different groups of people together.

Service organization and delivery

To probe the orientations of the administrators toward some of the dilemmas involved in employing different program methods, a variety of issues were posed to them. The "quantity-quality" dilemma was raised first. They were asked: When faced with the alternatives of providing services to more clients at the expense of quality of services, do you usually choose to serve the maximum number of possible clients, even though the quality of service may not be as good as it could be, or do you usually choose to serve *fewer* clients to maintain the quality of service? Nearly six in 10 (58 percent) said they would choose the latter–to serve fewer clients; a quarter (25 percent) would try to serve the maximum number of clients; the rest were unable to choose. Table 14 shows the extent to which administrators agree strongly or "somewhat" with selected issues of service organization and delivery.

Most administrators prefer to encourage the use of existing community services and apparently feel

strongly about making their own services available to all neighborhood residents. They are divided on the issue of neighborhood self-help programs as opposed to political action, however, although other data cited in Part I suggest that the centers are much more likely to emphasize self-help programs and place little or no emphasis on politically oriented social action. Yet at least half (51 percent) believe that it is feasible for centers to concentrate on both services and social action in the same program, six in 10 (62 percent) believe that client advocacy programs do not necessarily alienate community agencies, and nearly seven in 10 (68 percent) believe that resident involvement in the running of centers does not interfere with the efficient operation of center programs.

Just as the issues developed in the previous section have gained some prominence, so too have issues revolving around the use of semiprofessional workers and the implications for their potential effect on clients and their relationship with professional workers. In this respect administrators were asked about the relative strengths and weaknesses of professional and semiprofessional workers with regard to their work with clients, according to whether they agree or disagree with selected issues. Table 15 presents such data.

In general, administrators think that semiprofessional workers are better able to reach clients and that they are more open and friendly with clients, that clients find them easier to talk to—even about deeply personal problems—and that they are less likely than professional workers to be cool and distant toward them.

Professional workers are regarded as being, more reliable and dependable in their work habits, and as having more knowledge about community resources. At the same time, the data suggest that clients often feel that "professionals" don't really understand them.

Administrators are divided on the remaining question—whether professional or semiprofessional workers are more dedicated to their work.

The administrators were also asked a general question about the relationship between professional and semiprofessional workers on their staffs. Most—nearly seven in 10 (68 percent)—report that relations between the groups are entirely free from conflict and strain, nearly three in 10 (27 percent) report that they are somewhat strained, and fewer than 1 percent (.08) believe that relations are very strained.

Table 11. Formal opportunities for case coordination and service integration

Means of communication	Percent of centers holding event		
	At least weekly	At least monthly	Not at all
Case coordination			
Case conferences among center staff members	38.6	14.0	27.1
Case conferences among center staff and staff from other agencies	16.7	24.0	32.3
Service integration			
General meetings for all center employees	42.7	32.8	11.5
General meetings with representatives of other community agencies	7.3	49.0	14.6

The administrator's autonomy

The study was particularly interested in organizational goals, the extent to which the administrator has autonomous authority, and the degree to which participation in decisionmaking has been decentralized.

Administrators were asked to rank one of four broad organizational goals as the most important to the work of the center. More than six in 10 (63 percent) ranked effective programs as the most important, nearly a fifth (18 percent) ranked community acceptance and support, and fewer than one in 10 ranked efficient operations (9.1 percent) and high staff morale (7.5 percent). Half the administrators said they are

Table 12. Selected means of publicizing services in multiservice neighborhood centers

Means of publicity	Percent of centers
Speeches by center representatives at meetings of other groups or organizations	88.0
Formal meetings at the center	86.5
Announcements in newspaper	78.1
Direct mailings to residents	70.3
Posters in the neighborhood	68.8
Pamphlets or posters in other agencies	64.6
Pamphlets distributed door to door	62.5
Radio or television announcements	61.5
Center newsletter	50.5
Word of mouth personal contact	15.6
Announcements in churches, schools, and the like	5.7
Base	192

Table 13. The philosophy of administrators of multiservice neighborhood centers

Philosophy of administrators	Neighborhood centers	
	N	*Percent*
Center should develop a close relationship with residents and be responsive to the needs of the area	81	41.5
Center should belong to the people of the area and encourage their involvement and participation in decisionmaking	29	14.9
Center should help people become self-sufficient and independent	28	14.4
Center should make creative use of all possible resources	14	7.2
Center should be family-oriented and provide for the needs of the entire family	13	6.7
Center should foster understanding among people of different backgrounds and bring them together	11	5.6
Other	15	7.6
Base	195	

responsible only to their boards; the other half s[illegible]d directly to someone else in authority. Administrators were also asked how much autonomy they have in dealing with a variety of other matters. Their replies are reflected in table 16.

As table 17 indicates, administrators have the most autonomy when it comes to initiating new programs and hiring staff and the least in fixing salary levels and deciding the budget level. In fact, as many as four in 10 (40 percent) report that they have no autonomy in fixing salary levels and three in 10 (30 percent) report having no autonomy over budget.

Of all groups, board members are most often involved in decisionmaking and semiprofessional workers the least. It is only in the hiring of staff—most particularly, semiprofessional staff members—and daily operating decisions that administrators participate more often than board members. Professional workers are more regularly involved in decisionmaking than semiprofessional workers, with the exception of one task—recruiting new board members. Though fewer than a fifth of the centers allow for such participation at all, as many semiprofessional as professional workers are involved in this process, apparently calling on the semiprofessional worker's knowledge of neighborhood leaders as potential recruits for the board.

Generally speaking, then, board members establish policies, administrators decide daily operating procedures; and in the third or fewer centers in which they regularly participate in decisionmaking, professional workers contribute to goal setting and operating procedures. Professional workers do not regularly participate in decisionmaking in most centers and semiprofessional workers are even less involved.

Reference groups and administrator satisfaction

Here we deal with "who counts" as far as the center is concerned and describe those aspects of the administrator's job and those aspects of center operation about which he is most satisfied.

Administrators were asked to judge how important

Table 14. Administrators' agreement with selected issues of service organization and delivery

Issues	Percent in —	
	Agreement	Disagreement
It is probably wiser to help residents to the advantage of existing community agencies than to try to provide all needed services within the center itself	88.4	7.4
Neighborhood centers should make their services available to all residents regardless of income	81.7	13.3
Neighborhood self-help programs may instill some degree of neighborhood pride in residents but fail to deal with the more important "political" facts of life	45.3	39.0
It is usually not a good idea to try to provide effective services and promote aggressive social action both within the same center program	33.6	50.6
The greater the involvement of neighborhood residents in the running of a center, the more likely they are to interfere with the smooth and efficient operation of programs	26.2	68.1
A strong client advocacy program unnecessarily alienates the good will of community agencies	18.7	61.8
Base	241	

it is for various groups of people to think that the center is doing a good job—the people important to the survival and success of the center operation. As table 18 indicates, administrators most often believe that it is important for clients and neighborhood residents to be satisfied as well as the center staff and board of directors. In contrast, more than a quarter of the administrators say that it is *not very important* for local political leaders and nearly a fifth say it *is not very important* for civil rights groups to be satisfied with the center's work.

Administrators are most satisfied with their freedom, flexibility, and authority and least satisfied with their salaries. Indeed, three of every 10 (30 percent) are dissatisfied with their present salaries. However, though data presented in table 19 suggest the limitations of their relative autonomy, they, nevertheless, seem quite satisfied with their authority and flexibility.

Most administrators are generally satisfied with the operation of their centers, as table 20 indicates. In comparing the various aspects of their operations, administrators are most likely to be satisfied with the job their staffs are doing and the cooperation they get from their boards of directors. But a much smaller number are satisfied with the support they get from the neighborhood and the cooperation they get from other agencies. They are least satisfied with their efforts to reach the people who most need help.

Summary

The data presented in this report may be summarized as follows:

–Most of the centers seem to have a fairly simple organizational structure about which workers are reasonably clear and within which they operate rather informally and maintain friendly relations.

–Administrators tend to keep formal rules and regulations to a minimum and are less concerned with formal organization and authority than they are with whether workers are doing a good job.

–Most of the centers have a policymaking board and seek people with a real interest in the center to serve on it. Both an ability to listen and an ability to speak up are highly valued attributes in board members.

–Professional workers are most likely to be employed full time and semiprofessional workers to be employed part time.

–Centers engage in a combination of individual and group activities and rely on a generalist approach to problem solving. Few have highly specialized functions for which full-time specialists are hired. Staff workers are involved in outreach programs, rotate intake, and, for the most part, followup their own clients.

–Centers call other referral agencies and set up appointments for their clients, but few provide direct transportation or go with the clients themselves regularly.

Table 15. Administrators' agreement with selected strengths and weaknesses of professional and semiprofessional workers

Strengths and weaknesses	Percent of administrators–	
	Agreeing	Disagreeing
Semiprofessional workers seem to be able to reach more clients	60.1	21.6
Clients seem to be able to talk more easily to semiprofessional workers	56.4	22.0
Professional workers are more reliable and dependable in their work habits	50.2	27.0
Clients often feel that professional workers really don't understand them	46.4	32.3
Professional workers tend to be more cool and distant toward clients	33.2	44.4
Semiprofessional workers know more about resources available in the community	32.8	45.2
Semiprofessional workers are more dedicated to their work	32.7	32.0
Clients seem to have trouble talking to semiprofessional workers about deeply personal problems	27.0	49.4
Professional workers seem to be more friendly and open with clients	23.2	43.2
Base	241	

Table 16. Administrators' relative autonomy over selected service areas

Service area	Percent reporting–	
	Great autonomy	Little or no autonomy
Initiating new programs	55.2	7.9
Hiring staff	50.6	24.1
Establishing program policies	42.7	14.5
Arriving at the amount of the total budget	17.0	50.2
Fixing salary levels	12.4	55.6

Table 17. Involvement of various types of specified decisionmaking tasks in multiservice neighborhood centers

Tasks	Percent regularly involved			
	Board members	Administrators	Professional workers	Semiprofessional workers
Establishing policies	85.5	42.3	17.4	8.7
Deciding how to spend the annual budget	74.7	52.3	15.4	5.4
Recruiting new board members	73.4	34.4	16.2	15.4
Setting center goals	70.1	60.6	33.6	24.9
Fixing salary schedules	65.6	36.9	8.3	1.2
Hiring professional staff members	51.5	52.3	7.1	1.2
Hiring supervisory staff members	50.6	56.0	5.8	.8
Hiring semiprofessional staff members	31.5	67.6	19.5	1.7
Deciding on day-to-day operating procedures	7.9	85.1	29.9	14.5
Base	241			

-Centers employ a variety of professional workers, but social workers and teachers are the only professional workers represented in any substantial numbers. Moreover, of those centers employing other kinds of professional workers, most employ only one. Centers do make active use of volunteers, however.

-About half have at least one worker outstationed from another agency. Of all community agencies, health-related organizations are most likely to decentralize such workers into neighborhood centers.

-Centers provide relatively few formal opportunities for case coordination or service integration, and some centers do not provide for these activities at all.

Table 18. Percent of administrators indicating which groups of persons are very important to the work of the center

Group	Percent of administrators agreeing	
	Very important	Not very important
Center clients	95.9	0.0
Center staff	91.7	0.0
Board of directors	88.0	1.2
Neighborhood residents	85.9	1.7
Key members of neighborhood organizations	62.7	4.6
Community power structure	49.0	14.5
Executives of other local agencies	41.5	10.0
People in relevant Federal agencies or national organizations	41.1	11.6
Civil rights groups	37.8	17.8
Local political leaders		26.1
Base	27.0	24.1

-Administrators see a close relationship and involvement with the people of the area as necessary and important—but few adopt family orientation or neighborhood group integration as focal points for their centers.

-Administrators see program effectiveness as their number one goal—but nearly four in 10 see one or another goal taking

Table 19. Administrator's satisfaction with selected aspects of his job

Aspects	Percent satisfied
Amount of freedom and flexibility you have in your job	85.1
Amount of authority you have	83.4
Progress toward the goals you've set for yourself	62.7
Amount of time you must devote to your job	60.6
Present salary	57.3

Table 20. Administrator's satisfaction with selected aspects of the neighborhood center

Aspects	Percent satisfied
Job your staff is doing	87.1
Cooperation you get from your board of directors	76.4
Progress your center is making	71.8
Support you get from the neighborhood	61.4
Cooperation you get from agencies and organizations	60.6
Efforts to reach the people who most need help	52.2

precedence–for example, community support, organizational efficiency, or staff morale.

–Most administrators believe that the center should be available to all residents regardless of income and that efforts should be concentrated on helping residents take advantage of existing community services.

–Most administrators believe that resident involvement does not interfere with the smooth and efficient running of the center and believe that a strong client advocacy program does not unnecessarily alienate the good will of community agencies.

–Administrators believe that semiprofessional workers are in many ways better with clients than professional workers, and though they concede that professional workers may be more reliable, dependable, and knowledgeable, they believe that clients often feel that professional workers do not really understand them.

–Centers are administratively centralized, and few centers regularly involve staff members in decisionmaking; indeed, many administrators themselves are not regularly involved in certain decisions affecting the operation of the centers.

–Centers are oriented to their clients, their staffs, their boards, and the residents of the neighborhood–in that order. They are less concerned with political leaders, civil rights groups, national officials, or other local agency administrators.

Implications

There are a number of implications for policy, programming, and further research flowing from the findings. The principal ones are these:

• The multiservice neighborhood center remains a rather generalized operation, both as reflected in the number and kinds of professional workers represented and in the degree to which the same staff members perform any number of different functions. Indeed, the typical center offers a variety of both individual and group services; and though we have no data that bear directly on this issue, it is not unreasonable to assume that both modes of service are frequently provided by the same worker.

• To the extent that workers are called on to play many parts and to wear many hats, some classic tradeoffs seem inevitable. The same worker is obviously more sensitive to the existence of multiple problems and more able to provide continuity for individual people with different problems. Time-consuming and risky transfers and referrals are thereby avoided and the likelihood of the client's maintaining contact with the center is increased appreciably. At the same time, the generalist worker may have neither the time nor inclination–not to say training–to become expert in different specialities. The person seeking help may feel more comfortable in discussing many different problems with the same worker. And working with only one worker may give him a feeling of greater coherence and continuity, but he gets this feeling at the cost of attaining more specialized and perhaps more competent help with his specific problems.

• So much of this is only to say that neighborhood centers have yet to "get it all together." Their generalist orientation and their preference for universalist programs by which services are made available to all neighborhood groups–regardless of income–would seem to pose particular problems. Many centers are quickly overwhelmed by the many claims on their scarce resources. And administrators seem inclined to limit service, cut back on number of persons served, and establish waiting lists in the face of such demands. All too often centers find themselves suffering from the same old problems as their larger and more traditional counterparts and calling on the same old bureaucratic solutions.

• Rhetoric to the contrary, the multiservice neighborhood center is hardly the last bastion of democratic participation; neither is it an organization in which all the problems of staff coordination and service integration have been solved. Staff workers do not regularly participate in decisionmaking, nor, for that matter, is the administrator always involved in the key decisions affecting the center's operation. These findings suggest that neighborhood centers are often embedded in an administrative network in which decisions continue to be made "downtown" or "upstairs." The center remains a relatively tight organizational structure in which the administrator enjoys little autonomy and authority. Nevertheless, they do not seem to be unduly disturbed; indeed, they seem relatively satisfied with the amount of authority they do have. Centers provide few opportunities for staff participation and involvement and for formal case coordination and service integration. Again, though we have no data that speak to this issue directly, it is entirely possible that the generalized operation and centralized administration of the center both contribute to this lack of coordination and integration. To the extent that everyone does everything, so to speak, there is little or no need to actively consult other service staff members. Moreover, a centralized administration may only serve to reinforce a situation in which horizontal communication is restricted. And again, though the potential for informal communication and coordination exists, the lack of formal structure leaves too much to individual good will and idiosyncratic behavior. Many a client must want to cry out–"Save us from the good will of well-intentioned workers!"

• Finally, some of the findings seem to fly in the face of conventional wisdom and raise critical issues for future directions. For example, the fact that administrators believe that resident involvement does not interfere with the smooth and efficient operation of the center is at odds with at least some anecdotal evidence to the contrary. Moreover, their belief that a strong client advocacy program does not unnecessarily alienate the good will of community agencies seems to defy some of the conventional wisdom and traditional folklore of service organization and delivery. We do not know at this time whether such responses of administrators will vary by the extent to which their centers are heavily engaged in resident involvement or client advocacy; subsequent analysis should

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Managing Social Services in a Period of Rapid Change

Charles W. Williams, Jr.

It is becoming evident that, no matter how desirable, drastic change is the most difficult and dangerous experience mankind has undergone. We are discovering that broken habits can be more painful and crippling than broken bones, and that disintegrating values may have as deadly a fallout as disintegrating atoms.

ERIC HOFFER

(The Temper of Our Time, Harper & Row Publishers, 1967*)*

Much has been said about the social change our society is experiencing and the fact that we must learn how to manage that change. Yet what has been said remains only the tip of an iceberg with many profound implications below. It is becoming increasingly clear that we are dealing with a qualitative transformation of our whole society. Few informed people any longer doubt that we are actually undergoing a major historical transition into what has been termed a postindustrial period. This awareness began to emerge in the mid-1950's as it became apparent that dominant economic trends were transforming the distribution of the labor force so markedly that employment in the service and related sectors (such as government, education, and health) began exceeding employment in the traditional agricultural and production sectors (such as farming, steel, and automobiles).

However, it soon became apparent even in the 1950's that this economic-oriented labor distribution picture was far too narrow to accommodate the full range of basic changes that were rapidly surfacing. During the late 1950's and 1960's, an array of studies and social science literature began to detail fundamental changes in individual and social psychology, family roles and structures, philosophical and religious values, political attitudes, multinational economic entities, and many other areas. It now seems clear that the scope and significance of the current transformation cannot be explained by any of these societal "snapshots." Collectively they point toward a major social transformation of such scale that our understanding might best be improved by the historic analogies seen in a qualitative comparison of the social, economic, political, and philosophical changes involved in the shift from the dominant agricultural feudal society of the middle ages to the dominant industrialized society found in the advanced countries of the modern world. It is sobering to realize that adaptations to the agricultural revolution developed over thousands of years, whereas the industrial age was scarcely 180 years old before it became apparent that our society was already transforming itself into a postindustrial era. In fact, most of the change occurring in the industrial age occurred during the past hundred years. Though opinions vary on how rapid and extreme the current transformation may ultimately be, the consensus is that we are experiencing accelerated rates of change. It is reasonable to postulate that during the next three decades we will create the basic processes whereby postindustrial societies will be managed.

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THE NATURE of a complicated industrialized society is that the decisions made within it have an extraordinary life. This could be seen originally in the shift from labor intensive to capital intensive aspects of economic choice. We have seen a steady shift toward automated production processes, substituting capital investments in machinery for labor costs. In addition, once laid, a modern road determines the pattern of travel for a much longer period than did a horse or wagon trail. Once we have built an airport, its location determines where airplanes can go. Now such capital investments determine many of the basic future patterns of regional economic and social development. Institutional inertia makes changes in these decision processes come slowly. For example, it is taking years to shift from highway-oriented urban transportation to mass transit orientation. When basic value changes are required to achieve redirection, an even greater inertia is usually seen. Think, for a moment, about how long it would likely take for the welfare services community to consolidate its fragmented units into an integrated comprehensive welfare services center.

It will be necessary within this time period to develop a sociological accounting system. This will be the beginning of a concept of social accounting (not unlike the concept of economic accounting) where one can see interpersonal relationships as a transaction in which there is a price and a cost and a mutually received benefit or disbenefit. If sociologists who are trying to make sure that we evolve such a system are successful, we will have the basis for a major revolution in politics and social systems. Evidence suggests that very few people are seriously thinking about these issues and no plans exist for handling them.

If the basic characteristics of the future are the products of decisions made today, it then follows that there is not a single deterministic future beyond the range of accountability for policymakers today; rather, there are a series of alternative futures among which societies and the world choose. This concept of "alternative futures" flowing as a collective consequence of contemporary decisions has led to the concepts of "inventable futures" and of "inventing the future."

Though the future is largely the product of today's policies, a new "future awareness" is necessary if these policies are to shape a future worthy of our heritage and consistent with our human values. A rapidly increasing body of data suggests that, should major innovations to achieve basic redirections of current trends not be invented, the probability of a workable high quality future is grim.

Even superficial reflection suggests that many policies appropriate to the industrial age are not likely to remain effective for the postindustrial period. Social welfare and rehabilitation services are among the major social subsystems most challenged by these realities.

Over the past two decades, but particularly accelerating within the past 5 or so years, there has been evolving a domain of intellectual inquiry known by a variety of titles: futures research, futuristics, the study of the future, societal forecasting, technological forecasting, and so on. I have used the term intellectual domain of study because this is not a new discipline. Rather, it is the application of a psychological attitude and a mode of thinking that incorporate a variety of disciplines and analytic techniques, both quantitative and nonquantitative. It would seem that this is a logical evolution in thought that is coming forth none too soon. Much of the data flowing from such analyses has led to a pervasive pessimism. Many of the most probable models projecting dominant trends lead to the "doomsday perspective." Though from a professional standpoint the projective pattern of quantitative trends is the most reputable probabilistic statement about the future, an analysis of such projections when put into long-range time frames reflects their extraordinary inaccuracy.

THREE BASIC VIEWPOINTS can be synthesized from the growing array of information and writing on the future. Taking the year 2000 as a convenient reference point, we might say that the first vision of the future would suggest that the year 2000 will be to 1970 as 1970 was to 1940. This is the projective view. Casual reflection on changes through the three decades of 1940-1950-1960 are sufficiently sobering in themselves. A decade ago that view would have been regarded as among the most sophisticated of forecasts. Today such a view is, in my judgment, properly regarded as naive.

Today a more sophisticated forecast would recognize the accelerating rates of change, suggesting that, conservatively speaking, when those change rates are taken into consideration, the next 30 years would be more like the preceding 90 to a hundred; and, hence, the year 2000 will be to 1970 as 1970 was to approximately 1880, or perhaps 1860, just before the Civil War. This is a modified projective view, which I shall call the rate of change theory. A moment's reflection on this comparatively conservative proposi-

tion is even more sobering than the first model of the future.

We must, however, accommodate a third possible view, which is that we are experiencing a major historic transformation comparable to the agricultural and industrial revolutions. It is conceivable that this transition might be made by the turn of the century. After all, if it began to be evident statistically in the mid-1950's, it surely began a decade or so before that, probably in the early 1940's or late 1930's. Consequently, it is already from 15 to 30 years old. Another 30 years means a 45- to 60-year transition period, a period not much shorter than the industrial revolution that is a part of our experience. This model leads to the proposition that the year 2000 may be to 1970 as 1970 was to some date late in the preindustrial period, say, 1650. It cannot be said with certainty which of these viewpoints is correct. They are each held by responsible spokesmen. The history of social change suggests that the last two are likely to be closer to the mark.

We do not, however, for this discussion have to resolve the issue; for whichever viewpoint is true, a conclusion common to all is that the critical issues that are likely to most significantly affect social welfare and rehabilitation services and delivery systems in the 1970's and 1980's are issues qualitatively different from those experienced in the 1960's or the 1950's. That is, we are likely to experience as many or more trend-breaking developments in the next decade or so as have been experienced in the past decade or so.

Think for a moment about planning in that context. How did planning for these social services perform in the 1960's? Whose planning documents in 1960 envisioned the evolution of Medicaid? The impact of expanding concepts of basic rights that began with the trend-breaking decision of the Supreme Court in 1954 about school desegregation? The political visibility and huge funding given to compensatory education, Head Start, the Office of Economic Opportunity, and other similar programs? Who discussed in their plan the implications of the emerging patterns toward participatory decisionmaking and control that is now loosely termed the new consumerism? Who would have guessed that we would approach by now the serious possibility of guaranteed incomes? The consequences of these developments in the 1960's were of much greater significance, I suggest, in the field of action than any of the projected budgets and demographic quantities to be found in reading 1960 planning documents.

There seems to be emerging a conventional wisdom that more comprehensive and longer range planning is required and that it, if done, will prove to be the instrument whereby we acquire the capacity for directing our affairs and managing this transformational process. This subject was discussed at a recent conference sponsored by the American Society for Public Administration held at the National Bureau of Standards. Throughout the conference ran the implicit judgment that the planning process is, or at least should be, a part of the decisionmaking process; and yet both decisionmakers and planners agree that planners are essentially outside the decisionmaking process. Though most decisionmakers readily agree that we must have better and longer range planning, most of them are also busily stating that long-range planning is a waste of time. Decisionmakers and managers see most planning endeavors as more or less futile or inadequate or abstract.

The following themes stood out in that conference:

- There is drastic need for profound and fundamental reforms in institutional performance throughout our social subsystems if we are to move toward a high quality future.
- Planning should be the most effective decision tool to manage that transition.
- Planning is not now an effective agent of change and does not show much promise of becoming one, if its evolution in the 1970's is a continuation of its development in the 1960's. Present concepts are not only inadequate but often wrong due to counterintuitive responses and unsought consequences that often increase the problems we are working most avidly to solve.
- These conditions and others contribute to a common dilemma shared by decisionmakers, administrators, and planners. This dilemma must be solved if a qualitative future is to be secured.

THE 1960's were especially important to social scientists and to the managers of social systems. First, they showed, I believe, the great compassion of the American people. The infusion of legislation and public funds into social welfare and rehabilitation and the fight against poverty exceeded even the most optimistic hopes of the planners of 1960. It is heartening to see this compassion confirmed in the political viability of national policies.

However, a second and perhaps more important awareness was brought to light by the very success of acquiring this legislation and these budgetary increases. The underlying assumptions were that our present delivery systems and concepts were adequate, that if we could just get the national legislation and sufficient

increments in public expenditures, the goals would be attained. Many of these assumptions have proved wrong. There is a new conventional wisdom for the 1970's: it is that our present delivery systems for social services are fundamentally inadequate—so inadequate in fact that they are not likely to produce the desired collective results even if expenditure levels are markedly increased.

This belief has led to a different ethos in the 1970's—a search for new ways of structuring delivery systems, starting from a sense that the present systems are not working. The President's statement, thus far unchallenged, that the welfare system has become a "monstrous, consuming outrage" is among the more dramatic illustrations of the point. Many concede that our medical systems do not deliver health care with a respectable degree of effectiveness. The list is familiar and long.

THESE ATTITUDES POSE a new challenge to the manager of social services for the 1970's. How can he redeem the faith bestowed on him by the American people and by the clients whom he serves? It is clear that this confidence is seriously eroded. Painfully we must acknowledge that this erosion has legitimate roots. How can we acquire the capability for opening to major innovation such complex subsystems? How can we blend and reblend the fragmented specialties into a series of ever-changing adaptive mechanisms responding to rapidly changing conditions but yet responsive to human values that we have long held and that we wish to hold long into the future?

No experienced professional person underrates the magnitude of such a task. The transition of such complex systems must be achieved "on line." We cannot, for example, "shut down the assembly line" to do the retooling for "bringing out the new model." The job is analogous to the continuous stream of ever-increasing production of the old model while the unfulfilled demands of the customers grow at a rate that would make a private market analyst gleefully enthusiastic.

If we are to achieve these adaptive and innovative characteristics, it is necessary for the policy process to shift from a reactive to an anticipatory mode. A number of studies of the American policy processes have emphasized the presence of one dominant, common characteristic in virtually every policy. They are pragmatically reactive to events after the events have occurred. In the public management sphere, those events have usually reached crisis proportions. Solutions, because they cannot be carefully worked out, are crash solutions. It is more and more clear that the continuation of that form of policymaking carries an increasing and intolerable social cost at best, and catastrophe is not improbable.

At least two dominant articles of managerial faith require modification if we are to succeed in improving the policy processes as required. One is that we must deal in the context of strategic time-frames and strategic thought. These time periods are neither magical nor uniform designations. They may be 5 years but are most likely in complex social subsystems to require time horizons that include understanding the implications of present actions and the issues to be confronted at least one, perhaps two, or sometimes three decades into the future.

The second article of faith to be overcome is the one that says "I can only understand a small part of the totality; all of these other things are beyond my control, hence, I shall reduce the problem to manageable proportions." No one can argue with the validity of such a position with respect to execution and performance. Specialization of labor and function is, of course, a reality of our time. It seems, however, that those responsible for policy formulation are essentially "copping out," are taking the easy way out, when they insist that their policy visions also be a tunnel projection of the specialized sphere of execution.

Many, perhaps most, knowledgeable policymakers agree with three propositions. The first is that policy should be made in the context of second, third, and fourth order consequences; that is, they should take into account the interdependence of subsystems. A number of significant efforts are being made to achieve this improvement. The syntheses of the various relationships among programs and departments worked out in the present proposals for the welfare reform program are examples that this effort may be bearing fruit.

The second agreement is that policies should be made with an understanding of their longer range implications and with an understanding of the dynamics of the future social environment within which those policies are likely to be acted out.

The third agreement is that solutions to contemporary problems are often indirect and entail the coordination of activities, public and private, beyond our present capacities; for example, we now believe that an effective way to achieve educational objectives for ghetto children is to achieve a different policy for the location of housing for and the acquisition of jobs by

the parents of such children. Much of the solution, then, to the educational problem lies outside the classroom. Indeed, it lies outside the educational system.

Policy improvement in all three of these areas is seriously lagging, indeed is virtually nonexistent in the last two. Yet there is hope, for the lessons can be taught to those willing to learn—there is hope that the challenge can be met by those willing to rise to it. It is becoming possible to develop the kind of strategic information necessary to anticipatory policy formulation. Though such information is still quite crude, it is also quite useful. It doesn't have to be perfect, only good enough. The active and continuing interaction between policymakers and those few centers that have the capacity for developing these strategic assessments and analyses is essential to effective management in the coming decade.

MANAGERS ARE REQUIRED to adapt to attitudes about the future such as the recognition that it is largely knowable; largely the product of their decisions and of the decisions of persons like themselves; and largely inventable. Also they must adopt an attitude that systemwide strategies are possible and that their responsibility entails no less than the full degree of coordination. In the anticipatory framework, such integrated synthesis is plausible. It is essential if the fragmented, specialized institutional structures performing delivery are to interact in a symbiotic relationship whereby they collectively produce the organic objectives we all seek. Managers must accept a new epistemology for program innovation, an epistomology moving from an incremental projection of present inertias to one of basic reform and flexibility. We must move from concentration on institutions and systems toward concentration on persons as individuals.

One of the areas of concentration must surely be that of the policies affecting the lives of aging Americans. The population is stratified by age and function—pre-workforce, workforce, and post-workforce. The retired, elderly, and aged are considered as one group, and a person is assumed to enter the group at about age 65. The average man can expect to live another 14 years, the average woman another 16 years. Retirement is regarded as a period of earned leisure. (The aging, however, are regarded as a social overhead rather than as a national resource.) The government assumes that its programs supplement private savings or annuity programs and not that they constitute full subsistence support.

Many values and assumptions underlying present policies are already largely invalid and will become even more so. If they continue to dominate policies, their economic and social costs will become unbearable. To set new directions, we must develop goals that will permit a new role for aging Americans, supported by new economic, institutional, and technological concepts. Earlier retirements, under existing pension and employment situations, will lead to an increasing demand for public resources to fill the support gap; in 1960 one of eight men between ages 55 and 64 was no longer in the workforce—by 1980 this could be one in four. Average life expectancy, even without major research and breakthroughs, may increase by 10 to 20 years by the year 2000. The number of persons over 65 may fluctuate significantly as a result of policy choices in the next several years. Present plans may, by the year 2000, accommodate less than half of America's retired persons. Despite a 79 percent per capita increase in Federal expenditures in their behalf in the last 6 years, persons over age 65 were relatively worse off at the end of the decade than at the beginning—yet this growth rate cannot be sustained. By the same token, a leveling off in the growth rate of Federal expenditures will force more stringent criteria for public assistance or more severe deprivation for the elderly.

If the aging person is to experience a reasonable quality of life, policies and institutional circumstances must permit each to retire to a life appropriate to his physical, psychological, and chronological characteristics. Many of our present policies and programs make this virtually impossible.

All projections, plans, policy modifications, and evaluations of needed changes in both the short run and long run are first based on the Bureau of Census projections of the numbers of aging persons. These same projections are also used to estimate the costs of various alternatives. There are now about 20 million Americans 65 or older; during the next 30 years, another 45 or 50 million Americans will reach 65; 37 to 41 million persons over 65 are expected to die, leaving a net increase of 8 million, or 40 percent.

These estimates do not provide for developments that will change drastically the number of aging Americans with whom policymakers must deal. These unexpected additional people will appear in significant numbers at both ends of the age spectrum: retired people between 55 and 65 and elderly people 75 and over.

Already more and more persons are retiring before

the age of 65; for example, half the social security beneficiaries in 1968 elected to receive benefits before reaching age 64. These choices for early retirement are generally assumed to be voluntary and desirable. Yet, psychological and sociological research indicates that under our present institutional structures and social environments, early retirement is often deleterious to a person. Moreover, these early retirements are not so voluntary as they appear. Both business and government institutions increasingly encourage early retirement or impose mandatory retirement as a means of reducing surplus workforce or of expediting a change in the skills and other characteristics of the institution's workforce. Because of the rapid change in technology and the evolution of the service economy, most technological obsolescence has occurred in the agricultural and production sectors. Older workers now comprise a disproportionately small share of the labor force in growth industries.

TECHNOLOGICAL FORECASTS predict a continuing and accelerating shift from a production economy to a service economy. The automation made possible by advances in cybernetic sciences make probable higher rates of technological displacement in the labor force. This means that the projects of the Bureau of Labor Statistics (which are based on historic trends) are likely to underestimate the combined impact on the labor force of automation and productivity increases. The development of the computer sciences has been accompanied by a rapidly expanding service sector that has temporarily hidden the computers' productivity impact on service industries. Unless policies are changed, institutions and industries will find it most economically advantageous to encourage, even to enforce, early retirement as a means of adapting to new needs in a rapidly changing technical environment.

What would the manager of social and rehabilitation services who wished to move toward this new managerial competence be concerned about if he were to begin to think of alternative strategies? Among the dynamics in the future that are likely to affect fundamentally social and rehabilitation delivery systems are these:

▶ *Behavioral technologies.* The entire range of neurophysiological, psychological, chemical, electronic developments which will carry the power to mold or control individual behavior.

▶ *Cybernetic technologies.* These will change fundamentally the capabilities for the organization of production and service systems, and their expanding impact will affect the demand placed on such systems. For example, we have not really begun to feel the social effects of the computer revolution. There are a range of technological displacements that are sure to occur as the capital investments in plant and equipment replace equipment of the 1940's and 1950's and the early 1960's (largely automated equipment) with automatic cybernated feedback and process integration equipment of the next generation of electronic technology. Our present strategy is to encourage early retirement as a means of reducing the retraining efforts. This strategy will likely reach the point of unworkability by the late 1970's.

▶ *Shifting demands.* There will be increasingly shifting demand to be more faithful to our human values and for those operating social service systems to fulfill psychological as well as physical needs.

▶ *Effects of downward urban trend.* The question here is what are the implications of the continuing downward trend of many of our largest cities, a trend that urbanologists now see as terminating in the "economic and social failure" of a number of American cities in the forthcoming decade?

▶ *The leveling of growth rates in public expenditures.* This seems imminent. Social and rehabilitation services may experience in the 1970's the same kind of leveling growth rates that science and research experienced in the mid-1960's. The signs for science policymaking were clear as early as 1960, and yet they were ignored by pragmatic men; ignored, that is, until they were real and the scientific community reacted with "shock."

▶ *More competition for public resources.* As these growth rates begin to level, we can expect increasing competition for public resources. Budget justifications are likely to become more rather than less demanding.

▶ *A new trend toward decentralization.* There seems to be a high probability that a new trend for decentralizing authority and responsibility will occur, perhaps simultaneously with an increased centralization of financing social and rehabilitation services.

▶ *New forms of accountability.* It seems clear that as the social indicators and evaluation research movements continue, there will be new and expanding dimensions of accountability for managers and professional persons deliverying social services.

The above thoughts are by no means comprehensive. They are, rather, simple illustrations of a number of developments likely to occur in the 1970's, largely outside the control of managers in specific programmatic areas; events are likely to have a greater impact on the managerial activity, responsibility, and challenge than anything shown in the planning documents of 1970.

BY WHAT CRITERIA does today's manager or policymaker judge present decisions to be more effective in the coming years than past decisions are now judged to have been? It is now becoming possible to provide improved insight into that question; whether or not managers and practitioners will use that capability is yet an open question. It will be a shame if they don't.

Assessing Service Delivery Methods

Some Unsettled Questions

Neil Gilbert

Local social services increased considerably during the 1960's. Stimulated by national legislation to assist communities in dealing with poverty, mental illness, unemployment, delinquency, education, and the general quality of urban life, the development and growth of local services were accomplished, for the most part, with remarkable dispatch and no small amount of confusion. Attendant on this helter-skelter expansion is the increased importance of service delivery problems. Such problems do not spring from a shortage of ideas about how to improve delivery. On the contrary, social planners and public administrators have many methods of delivering local social services to choose from. Their problems center on resolving their uncertainty about which method will best do the job.

Critical analyses of the delivery of social services tend to be organized around four kinds of problems: fragmentation, inaccessibility, discontinuity, and unaccountability.[1] Plans to reform the organization and delivery of social services usually concern one or more of these problems, though they rarely concern all.

For a brief operational description of these problems, consider the hypothetical case of Mr. J. After being hurt in an automobile accident, Mr. J is rushed by ambulance to ward A, where he is examined. From ward A he is taken to ward B, where he receives medical treatment. He is then taken to ward C for rest and observation. If wards A, B, and C are in different parts of town, operate on different schedules, or provide overlapping services—that's *fragmentation*. If the ambulance disappears after dropping him at ward A—that's *discontinuity*. If the distance between the accident and ward A is too far for the rapidity of services needed, or if Mr. J is not admitted to ward A because of social class, ethnic background, or the like, or he is taken to a ward for mental patients—that's *inaccessibility*. And when any or all of these circumstances obtain and Mr. J has no viable course of redress—that's *unaccountability*.

These problems have many facets, are interconnected, and span a broader range of issues than I describe. Problems of *fragmentation* concern organizational characteristics and relationships, especially coordination, location, specialization, and duplication of services: Are services available in one place? Do agencies try to mesh their services? Problems of *inaccessibility* concern obstacles to a person's entering the network of local social services: Does bureaucratic selectivity based on social class, race, success potential, or other characteristics exclude certain persons from services? Problems of *discontinuity* concern a person's movement through the network of services and the gaps that appear as an agency tries to match resources to needs: Are channels of communication and referral lacking? Problems of *unaccountability* concern relationships between persons served and the decision-makers in service organizations: Is the person needing help unable to influence decisions that affect his

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circumstances? Are the decisionmakers in the service organizations he must turn to insensitive or unresponsive to his needs and interests?

Service delivery methods

At least six methods of solving these kinds of problems can be identified. They are *coordination*, *citizen participation*, *role attachments*, *professional disengagement*, *development of new agencies*, and *purposeful duplication*. To direct the description and analyses of these methods, three questions are posed in descending order of abstraction: What global properties of the delivery system do the methods seek to alter?[2] In what specific forms are these changes manifest? What are their potential consequences?

As depicted in the table, three basic properties of the delivery system are variously affected by the proposed methods. For example, coordination and citizen participation impinge in different ways on the bureaucratic hierarchy of the system. Role attachments and professional disengagement alter the combination of roles and status characteristic of the system.[3] The development of new structures and purposeful duplication change the substantive composition of the elements in the system.

Coordination. Social service workers, along with members of other nonprofessional groups, are quick to declare their faith in the generic, the whole man, and the comprehensive method of serving persons in need. They recognize the complexity of social causation and the interdependence of mental, physical, and environmental influences on people's ability to function and their chances in life. At the same time, professional workers are emphasizing specialization and the development of high-powered technical skill within narrowly defined fields of expertise. In one sense, they are advocating the coordination of services to mitigate the strains produced by the juxtaposition of specialization and the comprehensive method in the professional value structure.

Coordination is a method aimed at the development of an integrated social service system through either the centralization or the federation of service agencies.[4] These two processes are exemplified in recent changes made in the organization of local social services in England and in the United States.

In 1970 the British Parliament passed the Local Authority Social Services Act, prescribing a major reorganization of local service agencies. The reorganization entails the centralization of the staffs and functions of the children's and welfare departments, community development services, home help services, and other local agencies under the administration of newly created Local Authority Social Services Departments (LASSD). Attempts to integrate these services were made in the 1950's through the establishment of local agency coordinating committees. Titmuss[5] notes that these attempts were not successful; local services were still marked by "too much balkanized rivalry in the field of welfare," though demands for better coordination increased. In turning to LASSD as a mechanism for administrative centralization of decisions, the British use what Simon[6] recommends as among the most powerful of coordinative procedures.

However, efforts to increase coordination through administrative unification contain implications beyond merely posing a remedy for service fragmentation. For instance, administrative centralization of services usually increases the organizational distance between the persons served and decisionmakers. It is with this in mind that Townsend[7] sounds a note of caution about LASSD's creating a monopoly over certain services and the possible effects of such a development on social choice and accountability to service recipients. Centralization may lead to an internalization and, perhaps, heightening of what were previously interorganizational strains. The potential for intraorganizational conflict is sharpened, especially when a variety of heretofore autonomous agencies with different aims, technologies, and perceptions of the persons they serve and their problems are cast into a unitary organizational mold, as with LASSD.[8]

In addition, the consolidation of services under one administrative structure limits service accessibility to one organizational door. The "single door" access to the service network is a metaphor because the "door" may, in fact, be at a number of centers geographically dispersed throughout a community. It is a "single door" only in the sense that it functions according to the rules and regulations of one administrative authority—service network intake is concentrated in the hands of a relatively few gatekeepers bound by the same set of administrative policies. Operationally, the "single door" could prove to be a mechanism to rationalize service delivery from the standpoint of case referral and continuity or an impervious barrier to the local service network for those persons and groups of persons that, inadvertently or by design, do not fit the administrative criteria of eligibility for service.

Systemic effects of service delivery methods

Methods	Systemic changes
Coordination Citizen participation	Patterns of authority
Role attachments Professional disengagement	Roles and status
Development of new agencies Purposeful duplication	Substantive composition

Another major way to effect the coordination of services is through federation. This method occasionally involves the geographic centralization of different agency resources but not their administrative unification. Recent efforts along these lines have been made in the United States through the "neighborhood service centers" sponsored by the Community Action Programs (CAP) of the Office of Economic Opportunity. Federation encompasses a variety of more or less formal and binding arrangements. Its variability is usually reflected in the amount of time, resources, and organizational decisionmaking authority member organizations invest in the joint enterprise.[9] Warren[10] distinguishes between a federation and a coalition thus: the first is a continuing collaboration with a formal staff structure that has decisionmaking authority generally subject to ratification by component agencies; the second is informal and ad hoc and agencies do not share decisionmaking authority or modify their authority to accommodate the arrangement.

Federative arrangements require that organizations pool skill, resources, knowledge, and manpower in a cooperative endeavor. The costs to member agencies of such an undertaking frequently are higher than the organizational benefits of coordination.[11] By and large, the goals and policies of local service agencies are not like interlocking pieces of a jigsaw puzzle that given time, patience, and a constructive mentality can be fit neatly into the frame of a common cause. With some difficulty an awkward fit can be accomplished, but at a forfeit of organizational autonomy that many agencies are unwilling to endure. Thus efforts toward federation often result in loose knit coalitions that fall considerably short of ideal. For example, one study of neighborhood service centers indicates that the component agencies are considered to be "working together" because they are situated in the same center. Though such proximity makes communication easier, it does not dictate cooperation. As the study shows, the component agencies operate as autonomous organizations, responding to their particular goals, policies, and needs, which at times are different from those of the coordination staff, the persons served, and neighborhood residents.[12]

In comparing administrative centralization and federation as means to coordinate local social services, the crucial distinction resides in each structure's control mechanisms—that is, the restrictions and inducements among the component service units. Federative structures involve a voluntary collaboration of autonomous agencies wherein cooperation is based primarily on reciprocity; units in these structures are not bound to a formal hierarchy of positions based on rational-legal authority, as under a centralized administration such as the LASSD. Compared to bureaucratic authority, reciprocity is a tenuous control mechanism. It is operative, as Dahl and Lindbloom[13] note, "provided that the people have the same norms and conceptions of reality." The norms and reality views of the people who administer local service agencies, however, do not always fit this prescription.

Citizen participation. Unlike coordination of service methods where redistribution is geared to take place among agencies, citizen participation is aimed at the redistribution of decisionmaking authority and control between agencies and the persons served. The rationale as applied to delivery systems is that when service recipients choose people like themselves for positions that influence service delivery decisions, they are guaranteed access and accountability. Neither the good will of professional workers (viewed at best as paternalistic and at worse as nonexistent by the most militant advocates of citizen participation) nor bureaucratic rationality is considered sufficiently reliable to secure responsiveness to recipient needs because both professional workers and organizations have multiple objectives, their own survival in the system being foremost.

Similar to coordination methods, the redistribution of authority through citizen participation is distinguished according to different levels or types of participation wherein authority is shared to varying degrees. There are almost as many typologies of citizen participation as there are social scientists who write on this subject; but ignoring the various nuances, three modal types usually emerge.[14] The first is nonredistributive participation or psuedoparticipation, which may involve therapy, education, or plain deception: in any

case, it makes no perceptible change in the established pattern of authority. The second is nominal participation or tokenism: citizen influence on decisionmaking authority is clear and present though only to a degree that makes very little practical difference. The third is redistributive participation or "power to the people": here the shift in authority is such that citizen participants are able to exert substantive influence on decisions affecting the delivery system.

In citizen participation the means is valuable in itself, its value being "democracy." However, a system can be made democratic and at the same time suffer a deterioration in service delivery. If so, the method may be valid for broad political reasons but not for the objectives considered here. The basic assumption, however, is that a democratic delivery system will, indeed, be more responsive to recipient needs than a system where decisionmaking is reserved only for professional persons.

Although participatory democracy connotes the idealized New England townhall meeting of early times where everybody had a right to vote (except, of course, women, slaves, and persons too poor to own land), in practice citizen participation invariably requires the election or appointment of representatives. People simply do not have the time or inclination to participate in the making of every decision that affects them. The point is that, rhetoric notwithstanding, this method must come to grips with the notion of representativeness and the concomitant issues of *which* citizens participate, on *whose* behalf, and *how* they are chosen.

The recent experience of social agencies suggests some of the problematic facets of this method. For instance, neighborhood elections for city councilmen and other representatives to larger governing bodies can differ from neighborhood elections for citizen representation to local service delivery systems in at least one important respect—voter turnout to elect citizen representatives is, by comparison, usually negligible. In Pittsburgh less than 2 percent and in Philadelphia less than 3 percent of eligible residents participated in such elections in recent years.[15] Kramer[16] reports that the "numerous neighborhood elections in San Francisco and Santa Clara can best be described as psuedo-political processes." In addition to this, it is not uncommon for citizen representatives to be appointed by social service agencies or to be self-selected rather than chosen through an electoral process.[17]

Many endeavors to select citizen representatives lack formal accountability mechanisms to insure that the opinions and objectives of participants are valid expressions of local sentiment. In the absence of such accountability, citizen participation could reproduce, on a different plane, the very difficulties it seeks to ameliorate. As Weissman[18] observes, "community control tends to become control of the community by some elements to the exclusion of others and does not necessarily lead to more effective services." Under these circumstances "welfare colonialism" may be replaced by local planning and decisionmaking in which an elite group of citizen activists monopolizes the role of neighborhood spokesman. And, in extreme cases, citizen activists may even become a generation of "political bosses" who accumulate much of the power and many of the prerogatives they opposed in the "welfare colonialists."[19]

Role attachments. Social services, in the main, are performed by professional persons from the middle classes. Though services are offered to the entire community, a disproportionate segment of the people in need of services comes from the lower socioeconomic classes. Persons supporting role attachments as a better way to deliver services view the class chasm between servers and recipients as an impasse to movement into and through local delivery systems. They explain this impasse thus: the middle class professional worker is incapable of understanding the lower class person's outlook on life; is ignorant about the behavioral patterns and values of the people in the subculture served; doesn't speak their language and is regarded by them as "uptight." This is so partly because some professional workers are officious and partly because the norms of objectivity and impersonal treatment prescribe behavior that may be defined as unfriendly in the eyes of lower class persons who are ignorant about the behavior and values of the professional subculture, inarticulate by middle class standards, and are perceived as recalcitrant or even threatening in the eyes of professional persons. From this perspective problems of access and discontinuity are cast more in the shape of social stratification than organizational structure.[20] The case is put succinctly by Miller and Reissman:[21]

> The agencies must take upon themselves the responsibility for seeing that the individual patient gets to the service, or gets from one service to another. Without the assumption of this responsibility, the concept of continuity of care or services will become a meaningless programmatic shibboleth. Nor can these problems be resolved through administrative improvements alone. *A human link is needed.* [Italics mine.]

This human link is the local nonprofessional aide, a person who, by virtue of his style and special skill, can bridge the gap between professional agencies and lower class people, serving what Brager[22] describes as a social-class-mediating function. Certainly, there are other general economic and political values that support the employment of local nonprofessional workers, but it is only as expediters of service that their employment concerns our discussion of delivery systems.

At least three potential consequences of this method are self-defeating. First, the employment of nonprofessional workers may translate literally to mean that lower class persons will receive services that are amateurish or of a lesser quality than are offered by professional workers; that is, the nonprofessional worker's style and knowledge notwithstanding, the rich get professional service and the poor get participation. Second, even when nonprofessional workers are competent to perform services, efforts to integrate them into the delivery structure normally meet stiff resistance from professional workers. Pruger and Specht,[23] commenting about the source of resistance, say:

> It is inevitable because it is rooted in the virtually irresistible structural forces that shape organizational behavior. . . . In the case of the organizationally based professions, the forces that insure organizational discipline complement the pressures that induce professional reliability. And because much of the professional's self-image rests on this perception of his dearly bought competence, competitiors arriving on the scene through nontraditional routes must almost certainly be considered impudent upstarts, if not conscious usurpers.

Finally, even when nonprofessional workers are effective in linkage roles and are integrated into the service delivery structure, the latter will vitiate the former and their effectiveness will wane under pressure to resolve the strains between bureaucratic conformity and the freewheeling style of local workers. After examining the integration of nonprofessional workers into agency structures, Hardcastle[24] concludes that the "diminution of the nonprofessional's indigenous qualities—the emphasis on primary role skills, extemporaneousness, and lower class behavior and communication patterns—appears inevitable because of the essentially bureaucratic nature of the organization."

Professional disengagement. Though the imperative of bureaucratic conformity, in the opinion of many people in social service, puts a crimp in the style of nonprofessional workers, forcing them to adopt a professional or quasi-professional way of working, it has also been observed that the same imperative seems to inhibit professional functioning. For example, Levy[25] describes a public welfare setting where the discrepancy between the needs of administrators and those of recipients poses an acute moral dilemma for many workers. He suggests that the high turnover rate of workers in this setting was related to the irreconcilability of their inner feelings with the stringent logic of welfare administration. Piliavin[26] puts the case more generally:

> Social work has acquired many of the earmarks of a profession, including a professional association that has developed and promulgated standards, goals, and an ethnical code for those providing social services. The members of this association and other social workers guided by its framework of values encounter a dilemma unknown to their early predecessors—they find agency policies and practices frequently in conflict with avowed professional norms.

Given these circumstances, this line of thought emerges: the way to improve the delivery of social services is not to tinker with bureaucratic structure but rather to disengage from it altogether; that is, professional workers go into private practice on a fee-for-service basis to circumvent the restrictions on service delivery posed by agency policies. In other words, they change roles from that of bureaucrat to that of entrepreneur. As many people who use social services could not afford to support a client fee system, it is further proposed that the financial base for implementing this method be furnished through government grants similar to grants for medical care to the aged.[27]

Allowing, for the sake of argument only, that government financing for private social services can be accomplished, this method has certain apparent limitations for service delivery. The private practitioner may have expertise in public welfare, child guidance, corrections, marital counseling, family service, school social work, services to the aged, and the like, but he cannot possibly be a specialist in all. In this sense he is subject to the same professional myopia as the agency-based worker, except that agencies may incorporate a variety of specialists. What is to prevent the private practitioner from imposing his particular brand of services on the recipient, be it education, therapy, or advocacy, rather than dealing with that person's special needs? And even for the least avaricious, the tendency to interpret recipient problems by the practitioner's field of expertise receives a dash of positive reinforcement in the fee-for-service proposition. As a means to improve the accessibility and coherence of the delivery system,

the entrepreneurial model, therefore, may prove in some ways less effective than agency-based practice.

Development of new agencies. According to this method, fragmentation, inaccessibility, and discontinuity of service, to a degree, are inherent features of delivery systems characterized by the professional-specialized-bureaucratic gestalt. Its objective is to change neither the combination of roles in various elements of the system nor the relationships between these elements through centralization or federation. Its advocates recognize that specialized-professional-bureaucratic services perform important functions despite their drawbacks as delivery mechanisms. Instead of changing roles and the like, this method involves changing the composition of the delivery system by adding a new element—one that is to function independently as a catalyst, to act on other service agencies, to pry open their entrances, and to insure that recipients make the proper service connections. In a word, *access* is to be provided as a social service.

Until recently, the provision of access generally was considered a marginal function of all agencies and professional staffs in the delivery system, rather than a core function around which to organize a distinct set of services. As a marginal function, access is unduly restricted by the narrow perspectives of agency specializations. Under these circumstances the access service relates primarily to the agency's core function instead of particular recipient problems. This phenomenon is not a byproduct of incompetence or malice. It is a normal structural reality of specialized service organizations. To make it easier for recipients to obtain services while maintaining a relatively high degree of specialization, it is proposed that a new structure be added to the delivery system—a "professionally unbiased doorway."[28] This doorway is to be created by developing special agencies offering case-advocacy, advice, information, and referral services to assist recipients in negotiating the bureaucratic maze.

Although it is in many respects a persuasive method, the consequences of access agencies may be more desired than assured: from the recipient's perspective a possible effect of this method is to further fragment and complicate service delivery. Though access services are becoming increasingly important in complex urban societies, they are nevertheless among the least tangible of social services. The recipient thus may see the access agency as merely another bureaucracy to cope with before the proper resources are matched to his needs.

This method is also likely to have a certain influence on the other service agencies in the delivery system. The addition of an access agency suggests that agencies providing other services will cut down on the access services they offer as a marginal function. For instance, pressure would be reduced on these agencies to make special referrals to other agencies for persons they are unable to serve; instead they would merely direct such persons to the access agency. The net effect of transferring the marginal access functions of many organizations to the core function of a single organization is presently unclear regarding the extent to which it lessens traveling time, expense, or confusion in a person's search for service. Moreover, the separation of diagnosis and treatment engendered by this action, though theoretically possible, may prove clumsy in practice.

Purposeful duplication. Here the method entails duplication of any or all the services available in the existing system, as compared to the previous method, which provides only for the development of agencies to serve special delivery functions. Purposeful duplication is advanced in two forms that have a surface resemblance but are dissimilar enough to warrant distinction: *competition* and *separatism.*

Competition involves creating duplicate agencies within the delivery system to compete with established agencies for recipients and resources. This method increases choice. More important, competition, in the belief of those who advocate this method, will invigorate agencies and professional workers, sensitizing them to recipient needs and producing greater enterprise and creative efforts at service delivery. The consequences, however, are not always so fertile as or as compatible with the motives. Instead of a healthy competition for recipients and resources, an internecine conflict may ensue between the powerfully entrenched agencies and those scraping for a foothold in the system, the outcome of which is reasonably predictable.[29]

Separatism differs from competition in both the systemic location of new structures and their purposes for being. New agencies are created and organized and kept *outside* the established delivery system. Competition is likely to be an inadvertent—and unplanned—byproduct of separatism, particularly for resources. The intention is to form an alternative network that would serve certain disadvantaged groups, those that the existing system serves poorly or not at all because of organizational and professional proclivities toward racial, ethnic, and socioeconomic characteristics. Pro-

ponents of separatism emphasize that this method contains social and political values for disadvantaged groups that transcend the improvement of service delivery.[30]

Duplicate methods in either form are very expensive. The money may be well spent if the new agencies become a dynamic force for desired changes in the delivery system and reach those persons who are usually excluded from the service network. Against this are the risks of expending scarce resources to produce fruitless conflict and to create even greater fragmentation.

Implications for research and policy

Six major methods of improving the delivery of local social services have been identified by the properties of the delivery system they seek to alter: patterns of authority *(coordination* and *citizen participation),* roles and status *(role attachments* and *professional disengagement),* and substantive composition *(development of new agencies* and *purposeful duplication).* They have been analyzed for their expected and unexpected consequences. And some indication has been given of how one method proposed to cope with one problem of service delivery may exacerbate difficulties in other directions.

All of these methods are plausible ways to develop more effective service delivery; they all contain different limitations and latent dysfunctions that might compromise or vitiate the advantages promised; and though a few methods may be complementary, there are obvious contradictions in using many of them simultaneously. Choices are required.

Currently, *coordination* appears to enjoy favor among Federal policymakers, as reflected in the proposed Allied Services Act of 1972. This can be a seductive idea. The idea of being able to exercise a degree of administrative control over groups of heretofore autonomous service agencies will have intrinsic appeal to almost everybody who has grappled with the problems of rationalizing local service delivery. Such attraction notwithstanding, even when coordination operates through administrative control, the integration of services may remain highly problematic.[31]

Before we can accurately judge the efficacy of coordination or any of the other reform methods, certain empirical questions remain to be answered. I will not try to detail all of these questions but rather will try to distill some basic issues related to each method that are ripe for more intense empirical investigation.

Coordination. Within what range and mix of services does coordination operate most effectively as a mechanism to integrate service delivery? At issue here are the criteria for selecting the number and types of services incorporated within a coordinating structure that would produce a minimum strain and maximum cooperation and exchange among service units. There is substantial evidence, for instance, that certain service functions (such as social action and direct services) create disharmony and strain when joined.[32] We have little evidence, however, of what is the optimum mix of services and whether coordination is more likely to improve service intergration when organized around a geographic base (for example, all services in a designated neighborhood), a clientele with special demographic characteristics (for example, the aged, young people, young married couples, and ethnic groups), functional areas (for example, health and employment), or combinations thereof.

Purposeful duplication. Under what circumstances do the savings that accrue to a large scale organization make the duplication of services severely impractical? The research suggested by this question involves cost-benefits analyses of the organization of social services. One major argument against purposeful duplication of services and in favor of coordination is the increased efficiency attributed to the latter. However, with different types of social services, the gain in efficiency may vary considerably. At the same time, coordination or administrative unification is usually achieved at the expense of diversity. Ultimately, value judgments will be made concerning the relative desirability of efficiency and diversity in the delivery of social services. The more information available regarding the economic costs and social benefits of duplication, the better informed will be these value judgments.

Development of new agencies. To what extent does the creation of an access agency facilitate the admission to local social services? One issue here has already been suggested—the addition of an an access agency to the local service system might have the unanticipated effect of decreasing the net amount of information and referral services provided within that system (because other agencies might diminish the information and referral services they previously offered). This question remains open to direct empirical investigation.

Another, more complex, line of study would involve a comparative analysis of the percentage of persons in need and searching for help that actually receives relevant services and how many bases these persons touch before such services are rendered by matched local service systems with and without access agencies.

Role attachments. What types of local nonprofessional workers are best suited to withstand the strains inherent in the performance of linkage functions between professional workers and the community served? At issue here is the fact that "indigenous nonprofessional" is a designation for a variety of people with diverse values, commitments, aspirations, and reference groups. And they are likely to possess different capacities for coping with the pressure toward bureaucratic conformity and professionalism. Accordingly, a useful line of investigation is suggested in a recent exploratory study that develops a typology based on the differences among nonprofessional workers.[33] This study found that certain types of local staff members appear to be better fitted than others to perform tasks such as bridge and outreach functions. Further investigation is needed to extend and substantiate these tentative findings.

Professional disengagement. How does the move from agency-based practice to private practice affect access to and continuity of services offered? Though the assumption in this method is that the delivery of social services will improve when the professional worker is free from the restrictions imposed by bureaucratic organization, there is little evidence either to support or dispute this effect. A line of inquiry here might involve selecting a few cities in which to compare private practice with agency-based practice, offering similar services with regard to the characteristics of the persons served, the percentage of referrals made, followups, and the like.

Citizen participation. To what degree does substantive citizen participation in service agency decisionmaking processes increase accountability to the population being served? As indicated, election or selection procedures for citizen participants are frequently such that citizens who actually participate are not formally accountable to the groups of service users they ostensibly represent. We lack careful comparisons of the decisionmaking behavior of citizen participants and the expressed wishes and interests of the people they serve and delineation of selection procedures that produce participants with a high degree of accountability. One issue for further investigation involves, for instance, the extent to which elected representatives (on a block, neighborhood, and citywide basis), appointed representatives, and volunteer (or self-selected) representatives differ in their accountability to the persons they serve.

EACH OF THESE UNSETTLED QUESTIONS contributes to the uncertainty that surrounds policymakers concerned with selecting the right method to reform the delivery of social services. To conclude that more research is needed (which it is), is the unblemished mark of an academician (which I am). To this advice the practitioner may nod abstractly in agreement while he continues to design and implement policy governing service delivery. That is to say in effect—policy choices regarding service delivery may eventually benefit from future investigation, but they will not await the results; choices will be made based on the knowledge we possess, imperfect as it is. Accordingly, if there is a more immediate purpose to be served by this analysis, it is to heighten our recognition of this fact: to fixate on any one method as a panacea to service delivery problems is to prematurely foreclose the options on other methods of largely untested and untapped potential. Given the present state of knowledge about the design and consequences of service delivery methods, efforts to exercise fully all of the available options appear to be the more practical policy course.

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Graduate Work Education at the University of Kentucky

The History of a Decision

Henry M. Barlow

During the 1960's, the demand for trained social workers reached historic proportions. Growing national concern for the quality of human services, coupled with massive social legislation, led to significant changes in the field of social work. One of these was the expansion of graduate education and the establishment of nearly a dozen new schools. Full-time student enrollment more than doubled, rising from 6,039 in 1962 to 13,311 in 1970.[1] Between 1960 and 1970, the Council on Social Work Education (CSWE) accredited 11 new schools. In 1970 three more schools were accredited and 10 others were working toward accreditation.[2] Counting the three schools accredited in 1970, the United States had 80 graduate schools of social work at the beginning of the 1970's. In the same time span, 1960-70, social work education also assumed greater responsibility for undergraduate education and for meeting the national demand for social workers.[3]

Federal legislation and social work manpower

Characteristically, the demand for trained social workers has always outstripped the supply,[4] though the number has dwindled and swelled with economic and social conditions. Responding to the social changes occurring in the Depression years, the supply of trained workers increased during the 1930's. But World War II interrupted growth. Some persons who might have gone into social work went instead into other professions or occupations because of war time needs. After the war many veterans used their GI funds for social work education, and the manpower supply increased. During the 1950's, however, enrollment in social work schools declined: the number of students receiving the master's degree in social work (MSW) dropped from 1,923 in 1950 to 1,612 in academic year 1956-57. Once again the tide turned; as college enrollment rose rapidly during the second half of the decade, social work enrollment also increased and 2,318 MSW's were graduated in 1961-62.[5]

Despite the increase in the number of graduates, schools of social work did not expect the rapid rise in demand for trained social workers the 1960's brought. Although some schools rapidly reached full enrollment and began turning away qualified applicants as early as the fall of 1963, the profession was not prepared to meet the increasing demand for trained social workers.[6]

In the fall of 1960, President-Elect John F. Kennedy appointed a task force to advise him on

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Appreciation is expressed to Blanche D. Coll, historian, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare; Ernest F. Witte, Dean of the College of Social Professions, University of Kentucky; and Constance P. Wilson, Associate Professor of Social Work, University of Kentucky, for critical reviews of the manuscript.

The research on which this article reports is being conducted under a grant (SRS-70-49) from the Social and Rehabilitation Service; U.S. Department of Health, Education, and Welfare.

health and social security. The 1962 Public Welfare Amendments to the Social Security Act were one result of the committee's recommendations to him and are the first of several pieces of important social welfare legislation passed during the Kennedy-Johnson Administrations.

To step up training for public welfare positions, the authorization for training grants under Title VII of the Social Security Act was liberalized, Federal matching funds were raised from 50 to 75 percent[7] and the Secretary of Health, Education, and Welfare (HEW) was authorized to subsidize the training of social workers.[8] Also, under the child welfare section of the Amendments, HEW could make grants to educational institutions for special training projects,[9] meaning that schools of social work could now obtain economic support for faculties and students. The effect on social work education was great—both the demand for trained social workers and the level of financial support increased.

The enactment of the Public Welfare Amendments made HEW's projections of the need for social work obsolete.[10] New data were needed and needed acutely. In January 1963 HEW's Under Secretary established a departmental task force to consider the issues of social work education. The committee's report, *Closing the Gap in Social Work Manpower,* was presented in November 1965.[11]

The significance of *Closing the Gap in Social Work Manpower* is that it pinpointed distinct areas of need, identified resources for program development, and charted manpower goals. A major problem confronting the task force, however, was the absence of a single comprehensive, up-to-date study of manpower. Consequently, its data on manpower needs were drawn from several disparate sources, including the 1960 survey of social workers made by the Bureau of Labor Statistics (BLS), U.S. Department of Labor; 1964 reports of agencies in selected fields such as health and medicine, public education, public welfare services, delinquency, social insurance, voluntary welfare services, and international social work services; and the 1964 membership report of the National Association of Social Workers (NASW).

Despite the limitations of these data, the manpower problem was obviously acute. The need for trained workers in public welfare was particularly pressing. The 1960 BLS study showed that only about 4.5 percent of social workers in public welfare agencies had some graduate education in social work, though authorities in the profession argued that at least a third of all social workers in such programs should have advanced education to effectively give the services required by law.[12]

In addition to the general manpower shortage, public welfare programs were characterized by regional variations. Eighteen of the 50 States had no schools of social work. The Southeastern and Southwestern States were particularly far behind the national norm.

In its conclusions the task force said that the gap between projected supply and demand for social workers with graduate education would approach 100,000 by 1970. Moreover, this projection concerned only programs for which HEW agencies are directly responsible.

To increase the manpower supply, the task force recommended that graduate and undergraduate education expand many times and rapidly. It also recommended that social work educators differentiate among social welfare tasks and support the development of new sources of manpower through the adult education, community college, and vocational education programs for which Federal funds were available.[13]

During the time the task force was conducting its study, two major pieces of social legislation were enacted. The Economic Opportunity Act of 1964 provided funds for educational research, work study programs, community action programs, and the like.[14] The National Mental Health Act of 1964 authorized large-scale teaching and training support.[15]

At its annual meeting in the spring of 1966, the Council on Social Work Education (CSWE) argued that the need for trained workers was already acute and would intensify. As a stopgap measure, the Council recommended the establishment of new educational patterns, including accelerated programs, more part-time study, the use of new teaching methods, and the expansion and improvement of undergraduate education. The Council also asserted that 30 new graduate schools were needed but did not elaborate on the basis for this argument.[16] Shortly after the meeting, the Council set up a new schools project to provide consultation to colleges and universities interested in establishing new schools; to stimulate national, State, and local interest; and to help develop a master plan for the location of new schools.[17]

Exploring a commitment

The University of Kentucky is one of the universities adding a graduate school of social work during the 1960's. The decision to establish the College of

Social Professions and the Graduate School of Social Work at the university occurred during the 1960's, an era of massive Federal social legislation, as pointed out; national social action such as the civil rights movement; and national concern for social work manpower. Though the college was actually established on July 1, 1969, the university explored its commitment to graduate social work from late 1964 to mid-1968.

The findings reported in this article are part of a larger study of the developmental process of the College of Social Professions.

This study will extend through the period of accreditation to cover the employment of faculty, development of curriculum, and selection of field placements as well as relationships with students, the university administration, and the larger social work profession against the background of social ferment and the consequent questioning of the professional social worker's role.[18] In the current setting it is evident that old and newly established schools of social work and allied disciplines face challenges to traditional philosophy and consequently to traditional educational contents and method.

Insofar as its decisionmaking process was unusual, as it appears to be in many respects, the analysis presented here of that process has all the limitation of a case study. But inasmuch as organizations hold common characteristics and respond in predictable ways to given stimuli, a few generalizations from the University of Kentucky's experience can be made for the possible guidance of other institutions.[19]

The university and its setting. The University of Kentucky is a comprehensive, multipurpose land-grant institution. As the principal State university, it is the only public institution of higher learning in Kentucky with legislative responsibility to the State as a whole, rather than to a given geographic area or region. As a land-grant institution, it has a long-standing commitment to public service as well as to teaching and research. It also operates a network of 14 community colleges. Established in 1865, the university has offered graduate degree programs since its founding and now offers 59 degrees, including many in graduate and professional fields.[20]

Like most U.S. colleges and universities, the University of Kentucky expanded rapidly during the late 1950's and 1960's and established a number of new colleges. These include the Colleges of Medicine and Nursing, Dentistry, Architecture, Allied Health Professions, Home Economics, Library Science, and Social Professions.

As the table shows, enrollment at the main campus in Lexington more than doubled in the last decade, and in the community colleges went up nearly sixfold.[21] Even more significant, however, is the growth in graduate and professional education reflected in the number of doctoral, law, medical, and dental degrees awarded in 1970-71 (see table).

Although a strong rural heritage persists, Kentucky is undergoing rapid industrial and urban development. Each Census reports a larger urban population. In 1970 about 40 percent of the State's population of 3,219,311 was concentrated in standard metropolitan areas, 12 percent in smaller urban places, and the remaining 48 percent in "rural" areas. Most of the urban population is located in the three metropolitan areas of Lexington, Louisville, and the Kentucky sector of Cincinnati's metropolitan area.

The nonwhite population of Kentucky is small for the South. Negroes constitute about 7 percent of the population and are concentrated in urban areas. The range of regional differences between rural, urban, Appalachian, and other residents of the State is more important than racial diversity.

Although the State's rate of population growth is less than the national average (5.2 percent from 1960 to 1970, as compared with about 13 percent), the rate of change in central Kentucky is much greater, particularly in the Lexington area. Between 1960 and 1970 its population grew from 131,906 to 174,323 (almost 33 percent).

The attraction of new industrial plants underlies this change. With completion of new interstate routes, the city and the university are more accessible to Louisville and Cincinnati (each about 80 miles away) and the State Capital, Frankfort (about 30 miles away).

Because social work education depends on community agencies for field placement, the growth of the community and its improved accessibility to other parts of the State make the development of a graduate program easier. Moreover, extensive population change in the State underscores the need for additional trained social workers.

Earlier social work education. A primary objective of the University of Kentucky's program has been the preparation of men and women for careers in public welfare agencies. Organized in 1944 to replace an unsuccessful graduate program dating to 1939, the undergraduate department was a unit of the College of

Indicators of change at the University of Kentucky, 1960-71

	1960-61	1970-71
Enrollment		
Lexington Campus	7,287	17,668
Evening and extension	1,304	1,907
Community colleges	1,588	9,180
Graduates		
Baccalaureate	1,012	2,399
Masters and Specialists	316	588
Doctorals	35	135
Law	35	121
M.D.	--	75
D.M.D.	--	48
Pharm. D.	--	6
Nursing	--	46
Architecture	--	25
Faculty (Full-time equivalents)		
	1962-63	1970-71
Division of Colleges	491	925
Medical Center	140	295
Community colleges	51	394

Arts and Sciences until 1969. The program was comparatively small and oriented toward professional practices as might be expected in a graduate program rather than toward liberal education as might be expected in an undergraduate program. In addition to the chairman, the department had one full-time and two or three part-time members. During the 1940's and 1950's, the number of students majoring in social work rarely numbered 50. In 1969 the department had only 55 majors and 156 students enrolled in all courses. As the university's enrollment expanded, so did the department's. By 1965 its majors had increased to 294 and the number of students enrolled in all courses to 426.[22]

The State, however, was not without graduate education in social work at a public institution. The Kent School of Social Work at the University of Louisville, then a municipal institution, had offered graduate work since its establishment in 1936. But Kent's enrollment was comparatively small until the 1960's. In 1956 it had only 29 students. Reflecting the general rise in enrollment in the 1960's, it had 62 students in 1963 and 114 in 1966.[23]

Initial exploration. Although the University of Kentucky was interested in graduate work earlier, the turning point leading to the establishment of a graduate school and its present program was reached in the fall of 1964.[24] As the university prepared to enter its second century in 1965, its new president, John W. Oswald, asked for a review of all departments to guide his planning. In October 1964 he appointed a three-member faculty committee, comprised of a psychologist, a sociologist, and a professor of social work, to review the social work department.

In its report, made about 2 months later, the committee examined the scope and quality of the program and analyzed as far as it could the State's demand for trained social workers.[25] Because the chairman of the department was then 65 years old and could, at most, serve only 4 more years, the committee projected its review beyond his term. Although not identified in the report, the committee pointed out that many persons, both on- and off-campus, including key representatives of the State's social work profession, were consulted.

Though concluding that the department's chairman had done an outstanding job and made "effective use of the extraordinarily limited and inadequate resources at his disposal," the committee nevertheless recommended a change of direction and outlined several actions, among them the following:

> The curriculum should be revised and greater emphasis should be placed on courses in sociology, psychology, and other liberal arts fields. Less emphasis should be placed on 'specifically-designed social work courses.'
>
> Given the chairman's age, new leadership should be found.
>
> The university should seriously consider developing a graduate school of social work.

On the last and most important item, the committee recommended that the university take immediate action to explore the idea of developing a graduate program. It should consult as early as possible Kenneth N. Kindelsperger, Dean of the Kent School; a CSWE representative; and Grace White of the Social Services Department, University of Kentucky Medical Center, an authority on social work education. The committee's consultants had included Dean Kindelsperger, who had "some initial proposals" on how the two universities might cooperate in graduate education for social workers.[26]

Should the university decide not to seek a graduate program as the ultimate goal, the undergraduate curriculum might be revised within the context of

another department—an alternative not recommended but seen as "necessary unless the present level of financial support for the program can be increased, perhaps by two or threefold."[27]

The recommendation to consult Dean Kindelsperger was particularly timely. How to bring the University of Louisville into the State system and its possible merger with the University of Kentucky were being widely discussed. Although the merger has not occurred, the two universities have worked together to some extent, as the next several paragraphs will show, and the University of Louisville is now a member of the State system of higher education.

On February 10, 1965, Presidents Oswald (Kentucky) and Davidson (Louisville) appointed a joint committee of six to consider the problems of social work education: from the University of Louisville—Dean Kindelsperger (chairman); William McGlothlin, Vice President; and Howard Borsuk, Professor of Social Work; and from the University of Kentucky—Lewis W. Cochran, Provost; Harold Wetzel, Chairman of Social Work; and Grace White. The committee was given this charge:

> [To] (1) Recommend ways by which the two universities and the state and the community colleges appropriately can integrate their programs into a logical and efficient system of social work education to meet public and voluntary agency needs for adequately prepared welfare personnel; (2) Suggest effective ways in which present facilities of the universities and state may be utilized cooperatively; (3) Estimate the resources necessary for needed areas of expansion; and (4) Prepare a plan telling the steps necessary to implement these recommendations.[28]

In its reports, submitted to Presidents Oswald and Davidson in September 1965, the committee noted the large and growing need for professionally trained social workers (MSW's) and workers with undergraduate social work education to staff Federal, State, and local programs. The increasing demand for trained staff members was tied to recent Federal legislation—the 1962 Public Welfare Amendments, the Economic Opportunity Act, and the Community Mental Health Services Act as well as to expanded programs in mental retardation and physical rehabilitation.[29]

The committee had found that the State Departments of Child Welfare, Economic Security, Corrections, and Mental Health were facing an acute shortage of workers, particularly MSW's (many Federal programs require that key positions be staffed by MSW's). Given the manpower shortage, State agencies were finding it difficult to retain grants. They favored a new school at the University of Kentucky because its tuition was considerably lower than Louisville's. To meet State needs for the next 5 to 10 years, the committee suggested that at least 160 full-time graduate students be enrolled annually.

Three alternatives were presented as possible solutions to the problem: expand the Kent School, develop a new school at the University of Kentucky, or have the University of Kentucky take over undergraduate education and the Kent School graduate education in close relationship between the two institutions.

The most obvious solution was to expand the Kent School from 42 full-time students in 1962-63 to 101 by 1965-66. Because of new Federal and State grants, faculty and field instruction units had recently been added. Nine faculty-directed field units were being operated—three in the Lexington area, one in southern Indiana, one at the Federal prison in Ashland, one at the State reformatory in La Grange, and three in Louisville. The three Lexington centers were located in the University of Kentucky Hospital, the Veterans Administration Hospital, and the Federal hospital for narcotic addicts.

Under this alternative the major education base would remain in Louisville and field centers would be developed in other areas of the State. The advantage would be an existing base on which to build. Expansion of Kent would, however, call for State support not then available. Other sources of support could be explored, including the joint sponsorship of a graduate school with State assistance coming through the University of Kentucky's budget. In essence the Kent School said it needed some type of State assistance to aid in developing the program but did not specify the form the support might take. Its facilities were reaching their limits and, although the School did not present a case for capital or operating expenditures, continued expansion would necessitate revenue for both.

A second solution, at once more complex and less obvious, would be to develop a new school at the University of Kentucky. Insufficient opportunities for field placements stood out as the main obstacle here. Unless the school could enter other metropolitan areas, its total enrollment might have to be restricted to about 50 students. Should a new school establish field units in Cincinnati or Louisville, it would be competing with the Kent School for field placements. Moreover, there was no evidence that the State would gain should the University of Kentucky open another school. Rather, a subalternative was proposed: the two universities could establish a 1-year branch of the Kent

School in Lexington under a plan for development into a full program acceptable to both universities. However, the lack of access to a major metropolitan area would militate against a new school in Lexington unless it could move into the Cincinnati or Louisville area for field instruction.

As a third alternative, the University of Kentucky could assume responsibility for leadership in undergraduate work and for promoting its development in other State institutions while working with the Kent School in graduate education. If so, it should improve its undergraduate program and appoint a resident director to work with the Kent School in developing field instruction and, perhaps, in teaching courses. Using the experience of the University of Louisville and one other school in a neighboring State as a guide, the cost per student for either the second or third alternative would be about $3,800 per year.

The committee's conclusions included these:

- A new and separate school of social work at the University of Kentucky in Lexington was not feasible.
- The possibility of substantial State support to graduate education for social work in Kentucky should be explored.
- The two universities should enter a cooperative exploration to develop a joint program.

In the preferred plan—a joint program—the University of Kentucky should add a new faculty member to provide leadership for other colleges developing undergraduate courses and to expand its own program. For graduate work the two schools could appoint a resident director in Lexington to develop field instruction centers and to consider course offerings. This agreement should last for 2 years, during which time future relationships might be determined.

The recruitment officer for the State Department of Personnel took a different position from the committee. In a letter to the Executive Vice President of the University of Kentucky, dated May 1965, he urged that a new school be established and pointed out that he could guarantee adequate field facilities through State agencies in Lexington. Moreover, he said that an examination of the Kent program found all students to be receiving some kind of economic assistance and concluded that the program was almost self-supporting. This being the case, the costs of a new program to the University of Kentucky would be modest and the University could help reduce a serious shortage of trained social workers.

The joint committee surfaced a number of important issues, in particular the availability of adequate field facilities in Lexington and the effect of a new school on existing programs. And it brought State and University of Kentucky officials into more direct communication about manpower problems and to assess the level of State and Federal support for social work education. But no attempt was made to followup on committee recommendations for a joint program. On the surface the subject was dead from September 1965 until January 1967.

During 1966, however, changes affecting the entire system of higher education in the State were very much alive. The 1966 session of the State legislature raised five of the six State colleges to the level of regional universities. As such, these colleges could offer graduate education, including, in theory at least, social work. In another action the legislature commissioned a study of ways and means of bringing the University of Louisville into the State system. Doubtlessly, the University of Kentucky was influenced by these actions to reexamine its traditional role as the principal center for graduate and professional education.

The issue of feasibility

Despite the absence of formal action at the University of Kentucky during late 1965 and 1966, sentiment in favor of a new and separate school rose. State agencies repeatedly urged the university to create a new school. Clearly, State agencies perceived a growing need for trained workers and kept the university aware of their interest.

In January 1967 the Provost of the University of Kentucky (Dr. Cochran) appointed a high-level committee to assist him in determining what role the university should take regarding social work. Its members were Paul Nagel, Dean of Arts and Sciences; Joseph Hamburg, Dean of Allied Health Professions; Thomas R. Ford, Chairman of Sociology; Constance P. Wilson, Assistant Professor of Social Work; and Grace White of the Medical Center. When the committee was formed, the university had already contacted CSWE and was ready to invite representatives of the social work profession to the campus. The importance of the committee can hardly be overestimated. It became a vehicle for contact with social work educators, the CSWE, and a search committee for a consultant to prepare a feasibility study and later acted as the search committee for a dean for the new school.

Soon after its appointment, the committee invited Quentin F. Schenk, Dean of the School of Social

Welfare, University of Wisconsin-Milwaukee, to Lexington for consultation. After his visit in February 1967, Dean Schenk submitted a report supporting the establishment of a new school. The university, he asserted, had the institutional capacity to develop an outstanding school. Its other professional schools and graduate and research activities could contribute greatly to its development. Moreover, given the resources of the university and its commitment to serve the entire State, the issue of field instruction facilities should not delay development. Field instruction could be given through the Medical Center, student counseling programs, area extension centers, and community colleges. Of course, such a program would probably cost more initially than it would were social welfare agencies already located in the community. But the university would be able to develop new kinds of practice to meet the welfare needs of the State's urban and rural people.

Dean Schenk recommended seven procedural steps:

- The school should be built on existing undergraduate programs that could serve as a source for recruiting graduate students. With both graduate and undergraduate programs, the new school should train workers for the variety of skill needed in the field.
- Plan for immediate development of the master's program. Include the objective of developing a doctorate program as soon as resources permitted.
- Give the school independent status with its own dean.
- Consider bringing into the school such related educational functions as vocational rehabilitation and child and family development programs in home economics.
- Provide a mechanism (such as joint appointments) for linking the school to the basic social science disciplines.
- Resolve to support the program economically to the extent of its need so that it would not fail for want of resources. Though considerable resources might be available from external sources, a sizable (not specified) university investment would be required.[30]

Dean Schenk's reference to vocational rehabilitation and other programs that might be a part of a new school offered a possible solution to some problems. From the administration's viewpoint, the university had several social service programs located in units not conducive to growth and development. This fact led to the idea of a school of social professions instead of simply a school of social work.

The feasibility study. Despite its strong support for a new school, Dean Schenk's report did not fully address the issue of feasibility. He did not investigate manpower needs or resources for field instruction but presented his report after a brief visit to the university campus as a consultant. After receiving his report the committee continued to keep in touch with CSWE and met with other social work educators, including Ernest F. Witte, the Council's former director and head of the School of Social Work at San Diego State College, who came to the university for consultation in March 1967.

Dean Witte recommended to the Provost that a feasibility study following CSWE's formal guidelines be conducted. The Council, he said, should be asked to suggest persons who might conduct the study, and the need for a person familiar with recent developments in social work education and not committed to traditional field instruction should be emphasized. His suggestions were followed.

On the Council's recommendation Dean Witte was asked to accept the appointment and he did. The Council also suggested that these six aspects, involving many issues, be studied:

- The nature of field work practice in the area.
- The demographic, socioeconomic, and cultural characteristics of the area.
- The characteristics of the college or university.
- The effective demand for full-time graduate study.
- Resources for field instruction.
- The faculty and budget necessary for a new school.[31]

According to the Council, the feasibility study should provide "expert judgments of what kind of a school is most desirable for professional education of high quality.[32]

In contracting for the study, the university asked for an analysis of these aspects:

- The need for additional trained social workers.
- The existence of a reservoir of suitable potential student applicants.
- The adequacy of resources for field instruction.
- The justification for a second graduate program in the State.
- The suitability of a graduate program within the university, given its resources and stage of development.[33]

Because of its statewide commitment, the university requested an analysis of needs and resources throughout Kentucky, rather than in a region or area.

In its assessment of manpower needs, Dean Witte's feasibility study drew on national data and a questionnaire mailed to social agencies in Kentucky and in the Cincinnati metropolitan area. That a shortage of

trained workers existed was a fact well-established by the BLS 1960 Survey of Social Work Manpower, HEW's *Closing the Gap in Social Work Manpower*, and other national studies. Kentucky's need was evident from replies to the questionnaire mailed to State agencies (Departments of Child Welfare, Corrections, Economic Security, and Mental Health) providing educational leaves with stipends.

Career interest in social work was evident on the basis of national studies such as Sherman Merle's for CSWE, which showed growing student interest in social work, an increase in enrollment in accredited schools, and an increase in the number of students completing the MSW. Career interest in Kentucky was evident from the increasing enrollment in the university's undergraduate program and the number of other colleges providing undergraduate social work courses.

From the questionnaires returned by 48 agencies in the State and the Cincinnati area, Dean Witte suggested that 183 possible and 202 probable field placements could be used. The actual number could not be determined, however, until specific educational goals were established, criteria for selecting agencies developed, and the school was ready to act.[34] In addition to statewide resources for field instruction, university resources for social work education were identified, including the Colleges of Medicine, Law, Education, and Architecture, the student counseling and testing service, the health service, and the system of community colleges. Field centers for health services and mental health could be readily developed in health and medical resources already in Lexington. A third possible center might be focused on social change.

Dean Witte came out strongly for the establishment of a new school of social work at the University of Kentucky, despite full knowledge of the arguments of the joint report of the Universities of Kentucky and Louisville and a study commissioned by the Legislature recommending the merger of the two institutions. Urging the two universities to cooperate with each other, he recommended that the University of Kentucky review the feasibility study with representatives of the University of Louisville, the Ohio State University, and local NASW chapters. Moreover, he suggested that Kentucky restrict its initial field placements to areas outside Louisville and that the two universities establish a joint faculty planning committee. Finally, Kentucky should discuss the feasibility study with CSWE representatives for advice in planning the program.

Final action. On completion of the feasibility study in December 1967, the University of Kentucky could proceed with final planning activities. Though it wanted to create a school that would encompass other social service education programs such as vocational rehabilitation, the central issue was clearly social work education. Final steps could now be taken to establish the school. These steps would involve approval by the University Board of Trustees and the State Council on Public Higher Education plus action to obtain funds for the school and to recruit a dean and faculty.

On June 24, 1968, President Oswald presented the proposal to establish the school to the Board of Trustees. He proposed that a School of Social Professions (changed to College of Social Professions in 1970) with a department of social work be established and that the administration be authorized to recruit a dean and faculty to develop a graduate program leading to the MSW degree.

In support of the proposal, the report of the joint committee and the feasibility study were cited as evidence of the need for manpower and the new school. President Oswald also said that the university expected to follow the recommendations in the feasibility study for cooperation with CSWE, the University of Louisville, and other groups identified in the study.

Although initial emphasis would be on developing the MSW program, the undergraduate program would be reviewed and reorganized appropriately. The proposed designation of School of Social Professions, however, connoted the inclusion of other social service education programs as they might be developed by the university. The proposal was approved without opposition.

To be in time for consideration by the State Council on Public Higher Education in its meeting on July 1, 1968, the proposal for the new school was immediately submitted to the Council. Along with the feasibility study, President Oswald submitted a memorandum outlining the steps taken by the university in its exploration and planning process and the rationale for programs to be included in the new school. Noting the time requirements for accreditation of the school, he said that funds for the first year were included in the 1968-69 budget and that the school might enroll 40 graduate students in its first class in September 1970. Given the experience of other schools, an average total expenditure (including stipends) of $39,000 per student per year would be required, but typically 50 percent or more of the total costs could be obtained from extramural sources.

Several members of the Council observed that the request had not been received in time to be studied and that they did not know whether there was need for a second school of social work. In defense of the timing, President Oswald replied that the program could not have been submitted earlier because it had been approved only the preceding week by the Board of Trustees. One Council member moved that action be deferred until the issue of a closer relationship between the universities was settled, but this motion was amended to state only that action would be deferred. The motion was then passed as amended. The proposal for the school was approved at the next meeting. With this action the school was established and the university could proceed with the recruitment of a dean and faculty.

Conclusion

From this analysis it is clear that a number of forces influenced the university's course of action. In essence some elements of institutional and organizational change and their interrelations have been described. Nationally, strong social movements to alleviate poverty, racial discrimination, and lack of economic opportunity led to the enactment of social legislation that increased both the demand for trained social workers and provided greater resources to educate social workers and teachers.

As Federal legislation contributed to the need for trained social workers and to resources for educational improvement, social welfare institutions along with the social work profession and universities responded by expanding education programs. This study of the University of Kentucky presents a university in the midst of major change brought on by great increase in student enrollment and change in functions as it became more of a center for graduate and professional education. A combination of internal and external events led the university to act. The timing of the decision was clearly influenced by a number of local events, including the demand of State agencies for manpower and the issue of what relationship might be established with the University of Louisville, given the two universities' overlapping domains in professional education. In its choice of the title of School of Social Professions for the new school, the university indicated a desire to establish a base for other social service educational programs and to develop a new mechanism for administrative coordination. The wisdom of this choice remains to be seen, for though it may aid in the administrative sense of grouping programs together, other difficulties such as relationships between the professions and their development may well emerge.

In conclusion, a number of questions may be raised about the decisionmaking process. Unfortunately, other research in this area appears to be quite limited and the observations made here must be regarded as tentative. It is evident, however, that a critical manpower shortage was perceived—perceived as both immediate and long term. But would the same sense of urgency be found were the issues being faced now? Like other organizations, universities must be concerned with immediate and long-term needs and must try to strike a balance in their responses.

GIVEN THE NATURE of the educational problem described here, the course of the decisionmaking process is of interest. A rather extensive exploration process guided by the university administration culminated in approval of the program by the State Council on Public Higher Education. In a time of limited resources for educational programs, it seems clear that other institutions will be required to engage in even more intensive and extensive analysis for planning their programs. It appears reasonable to conclude, therefore, that much more thought must be given to the methodology of feasibility research. This is not to be critical of the process followed by the University of Kentucky or of the feasiblity study. It is to suggest, however, that the problems of educational planning are becoming more complex and that universities must be sensitive to a wider range of issues.

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[1] Encyclopedia of Social Work, *17th issue (New York: National Association of Social Workers, Inc.), 1971, p. 1,611.*

[2] *Council on Social Work Education,* Graduate and Professional Schools of Social Work in Canada and the U.S.A. *(New York: The Council), July 1970.*

[3] *Council on Social Work Education,* Social Work Education Reporter, *(New York: The Council), March 1966, p. 14.*

[4] *Mary R. Baker, "Personnel in Social Work,"* Encyclopedia of Social Work, *15th issue (New York: National Association of Social Workers, Inc.), 1965, p. 538.*

[5] *Ibid.*

[6] *Arnulf M. Pins,* Social Work Education and Social Welfare Manpower: Present Realities and Future Imperatives *(New York: Council on Social Work Education), 1/4175, mimeo., p. 8.*

[7] *Wilbur J. Cohen and Robert M. Ball, "Public Welfare Amendments of 1962,"* Social Security Bulletin, *Oct. 1962, p. 4.*

[8] *Margaret K. Adams, "State Public Assistance Legislation,"* Welfare in Review, *Oct. 1965, p. 10.*

[9] *Cohen and Ball, op. cit., p. 3; and "State Action on the Child Welfare Provisions of the 1962 Amendments,"* Welfare in Review, *Jan. 1964, p. 26.*

[10] *See Alvin L. Schorr, "Need for Trained Social Work Staff: A Ten Year Goal,"* Social Security Bulletin, *Aug. 1961, p. 13.*

[11] *U.S. Department of Health, Education, and Welfare,* Closing the Gap in Social Work Manpower *(Washington: The Department), Nov. 1965, p. ix.*

[12] *Ibid., p. 15.*

[13] *Ibid., p. 81.*

[14] *Ibid., p. 66.*

[15] *Ibid., p. 64.*

[16] *Press release issued by the Council on Social Work Education at its Annual Program Meeting, New York, Jan. 25, 1966.*

[17] *Report on the New Schools Project,* Social Work Education Reporter, *Sept. 1967, p. 13.*

[18] *For example, Harry Specht, "The Deprofessionalization of Social Work,"* Social Work, *Mar. 1972, pp. 3-15.*

[19] *To analyze the decisionmaking process, I studied university records and documents and conducted interviews with almost all of the principal persons concerned with the decision. With the exception of two persons, all members of the joint University of Kentucky-University of Louisville committee, the Provost's advisory committee at the university, and the review committee for the undergraduate program were interviewed. Moreover, we interviewed a number of State welfare officials who had urged the university to act and several faculty members in policymaking position who would be concerned with the development of new educational programs.*

Respondents were asked for an account of the decisionmaking process, including perceptions of their own role, if any, in the sequence of events. In all, 30 persons were interviewed during June and July 1970 and their responses contributed to the analysis of the event.

[20] *University of Kentucky,* Catalog *(Lexington: The University), Apr. 1971, p. 19.*

[21] *Data on enrollment, degrees, and faculty were abstracted from the* Proposal for the University Year of Action, *University of Kentucky, 1971. Note also the national increase in enrollment: "Degree credit enrollment in institutions of higher education in the United States has increased each year since the early 1950's, rising from 2.1 million in 1951 to 6.8 million in 1968 and an estimated 7.6 million in 1970."* Digest of Educational Statistics *(Washington: U.S. Department of Health, Education, and Welfare), Sept. 1970, p. 61.*

[22] *Ernest F. Witte,* Feasibility Study for a School of Social Work at the University of Kentucky *(Lexington: University of Kentucky), Dec. 1967, p. 32.*

[23] *Ibid.*

[24] *One example is a report of the Kentucky Legislative Research Commission in 1951 calling attention to the need for the university to develop a graduate program to provide trained manpower for the public welfare agencies.*

[25] *Albert J. Lott, Robert Straus, and Constance Wilson,* Report on the Department of Social Work and Its Chairman, Professor Harold S. Wetzel *(Lexington: University of Kentucky), mimeo., ca., Dec. 1964, p. 1.*

[26] *Ibid., p. 5.*

[27] *Ibid., p. 6.*

[28] *Kenneth W. Kindelsperger, Grace White, Harold S. Wetzel, Lewis W. Cochran, William McGlothlin, and Howard Borsuk,* Report of Joint Committee on Social Work Education, University of Louisville and University of Kentucky *(Lexington: University of Kentucky), Sept. 1965, mimeo., p. 1.*

[29] *Ibid., p. 2.*

[30] *Quentin F. Schenk,* Summary of Impressions Concerning the Establishment of a School of Social Work at the University of Kentucky, *mimeo., Feb. 1967.*

[31] *Council on Social Work Education,* Some Considerations on Expansion of Facilities for Social Work Education *(New York: The Council), mimeo., Dec. 1961. See also Eileen Blackey, "Feasibility Studies for New Graduate Schools,"* Social Work Education Reporter, *June 1969.*

[32] *Council on Social Work Education,* Guides for Establishing a Graduate Professional School of Social Work *(New York: The Council), No. 70-431-6, mimeo., undated.*

[33] *Witte, op. cit., p. 1.*

[34] *Ibid., p. 40.*

A Nutrition Education Service for Low Income Families

Nancy B. Leidenfrost

Although the United States is probably the best fed nation in the world, thousands of American families have diets that are nutritionally inadequate. Most of these families are at the low end of the income scale and are often socially as well as economically disadvantaged.

The Expanded Food and Nutrition Education Program (EFNEP) of the Cooperative Extension Service, U.S. Department of Agriculture, now a little more than 3 years old, seeks to improve the diets of low income families through education. Although Extension has been involved in nutrition education since its earliest days, the EFNEP reflects changes in methodology from past efforts to bring food and nutrition education to the public. The changes include a concentrated effort in reaching hard-to-reach families with low incomes, many of whom live in urban areas and are members of minority groups. Another change is that the service is rendered by paid nonprofessional workers called program aides, supervised by professional home economists. This is in contrast to other Extension Home Economics programs, which are conducted by volunteers, for the most part, and directed by the professional workers.

Extension Home Economics is a part of the Cooperative Extension Service established by an act of Congress in 1914 to help the people of the United States improve their homes, farms, and communities. The U.S. Department of Agriculture, State and local governments, and land-grant colleges and universities in the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands share in financing and supporting this national out-of-school educational program for adults and young people in cities, towns, and rural areas. Professional workers in more than 3,100 county Extension offices across the country plan and conduct the program, in cooperation with community leaders and volunteer workers.

Essentially, Extension Home Economics is a family-centered program—designed to serve families and persons of all age levels, including the young and the elderly; the disadvantaged; professional workers of other agencies; and the general public. The unique abilities of the home economist permit her to focus on areas of national concern such as family stability, family housing, consumer competence, family health and nutrition, and community and resource development. The Extension home economist is responsible for conducting home economics programs that reflect and meet the needs of today's families. Bringing nutrition education to low income people, with the help of nonprofessional workers, is a recent addition to the program.

Results of extended research to determine the effectiveness of program aide work with low income families were published in April 1972 and are highlighted in this article.

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The program aide: a new chapter in Extension

The program aide is the key figure in EFNEP. She (sometimes he) bridges the educational gap for low income families who may not be reached adequately by the existing Extension programs. Aides cross barriers to reach thousands of families who could not be reached in any other way. Living among the people they serve, they are readily accepted in hard-to-reach homes, where they stimulate confidence and trust. Though concerned with various family needs, their chief aim is to "improve diets through education and better use of available resources." Aides are hired, trained, and supervised by Extension home economists in counties or other jurisdictions.

About 9,400 program aides are now working part or full time for Extension Service in all the States, the District of Columbia, Puerto Rico, and the Virgin Islands, triple the number employed when the program started reporting in February 1969. They are on the job in more than 1,400 independent cities, counties, and Indian reservations. The sites were selected by State Extension Services and numbered about 650 the first year. Money for the program—which began with a $10 million allotment from the Secretary of Agriculture's funds—was $50 million in fiscal year 1972, appropriated by the Congress.

Qualifications for the aide position are generally the ability to read and write and, mainly, the ability to identify and communicate with low income families. Every effort is made to choose persons from the neighborhoods served. Aides represent many ethnic groups, including persons of Spanish-American, American Indian, and Oriental backgrounds as well as white and Negro.

The subject matter covered by the program includes the essentials of nutrition; meal planning; food buying, storage, preparation, and serving; sanitation practices; and other related aspects. Because conditions or problems may restrain or bar improved nutrition, the family also receives information about the U.S. Department of Agriculture's Food Stamp and Family Food Donation Programs that may help them improve their diets.

Of more than two million families served so far, about two of every three are from minority groups. Nearly half are Negro, about 17 percent Spanish-American, and about 2 percent American Indian. In addition, more than a million young persons have been reached through a 4-H type of program. Teenagers in many families are the food buyers and prepare the family meals. Efforts are made to work with these young people in the home, although most of those in the EFNEP program are reached by group methods.

The idea of the program aide was explored when Alabama launched a pilot project in 1965 in four counties to test the feasibility of using paid part-time nonprofessional workers to reach young homemakers and their families and to teach them homemaking skills. Extension home economists in the four counties recruited, selected, and supervised the nonprofessional workers.

Alabama's project proved highly successful, as its well-documented reports show. During that same time several other States conducted similar exploratory projects in both rural and urban settings, and their good results were valuable to Extension in initiating a national program.

The State Extension Services were prompted to act because they shared the Nation's concern for those Americans who are victims of unemployment, low educational attainment, poor housing, and poor health. They realized that lack of money is not the only reason for the poor health of people. Some lack the nutrition required for good health because they don't know how to select foods and plan and prepare nutritious meals. The program aide has become the home economist's extended arm to take information to such families.

The use of aides demonstrated that personal informal learning experience is important in assisting underprivileged homemakers to eat better and feed their families better. Such homemakers also need such an incentive to raise their level of living.

The pilot programs showed that paid part-time nonprofessional workers, under the direction of Extension home economists, could help the enrolled families improve their diets and, to a lesser degree, their general welfare.

Preparing the aide

The EFNEP aide works under the supervision of an Extension home economist. She is taught how people learn and how to teach and motivate them as family members to learn and apply what they have learned. She herself learns how to make effective home visits and conduct small group meetings. She learns to understand the families she serves and to observe and report progress. Basic nutrition, food preparation, consumer education, and management are essential parts of her training.

The Extension home economist, obviously, is the key to the aide's acquired ability and desire to get results with "her" families. And this professional worker has earned the vast credit given her for the national success of the aide program.

The aide's original training period takes not less than 3 weeks—of which at least 30 hours (15 lessons) are in the all-important fields of food and nutrition. Extension Service has developed six manuals for Extension workers to use in teaching aides. (See box.)

After receiving instruction on basic nutrition and training in teaching methods and the use of community resources, the program aide is ready to work with families. But her education continues through her employment. Every week or every other week she and other aides in her unit meet with the supervising Extension home economist. During these meetings the aide usually turns in her records, discusses her problems and plans, and receives further information on food and nutrition and related subjects such as home sanitation or consumer buying.

Inservice training is planned with the aides' help and from observations made by the home economist during visits with aides to homes. In addition, the home economist confers regularly with individual aides. Increased participation by advisory groups from the people served helps the aides focus attention on family problems and may guide the Extension home economist in carrying out program objectives. These advisory groups are organized by the aides and may meet on a community or county basis.

Another group of local people of particular value is the resource committee organized by Extension and made up of representatives of local agencies. Members of the committee are usually from agencies that provide a service to low income families, and they often refer families to EFNEP. The members may serve as resource persons in training the aides.

Training alone is not enough, of course, to keep the aides performing well. They need, and receive, support from professional workers and are recognized when they excel. Many States give certificates to aides when they complete the initial training. Others hold "graduation ceremonies" and "college days." Many aides have appeared on program panels and television and radio broadcasts and as speakers at group meetings.

Once established on their jobs, the aide may receive fringe benefits similar to those of professional workers. In many States these benefits include vacations with pay, sick leave, insurance, and the like and are equal to those professional workers receive. They are paid "the going wage" for the work they do—which varies from the basic minimum of around $1.60 an hour in some places to $3.50 in others, depending on the nature of their duties and responsibilities.

Teaching—the aide's role

An aide starts her job by visiting families and creating interest and support for further work with them. Families may be in a city housing development, in a village, on an Indian reservation, or on a farm.

Though much of the aides' activities center on food and nutrition instruction for enrolled families and young persons, they literally knock on doors or ring doorbells to see families who are potential enrollees. Individual families in an area covered by a program unit are often identified through community and church organizations, public agencies, community leaders, and the aide's personal knowledge. Families in the program may identify and recruit others, but most participating families are recruited by the aide. The aide usually represents the ethnic group with whom she works and "speaks its language." When she is fluent in a language besides English, her services are particularly valuable. A program aide fluent in Spanish may work chiefly with Spanish-speaking families.

The aide's major job is to teach nutrition and to suggest ways for the homemaker to prepare balanced and nutritious meals. The aide uses her knowledge of "ethnic foods" to help the homemaker plan and prepare more nutritious and balanced meals within

Teaching aide manuals

The following list contains the titles and prices of the six manuals developed by EFNEP for Extension workers to use in teaching aides. They may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Food and Nutrition Basic Lessons for Training Extension Aides (60 cents)

Food and Nutrition Supplemental Lessons for Training Extension Aides—Food Needs of Family Members (55 cents)

Food and Nutrition Supplemental Lessons for Training Extension Aides—Food Buying (60 cents)

Food and Nutrition Supplemental Lessons for Training Extension Aides—Meal Planning (45 cents)

Food and Nutrition Supplemental Lessons for Training Extension Aides—Key Nutrients (45 cents)

Food and Nutrition Supplemental Lessons for Training Extension Aides—Food Preparation (75 cents)

A seventh, *A Problem-Centered Approach*, is in production.

established food patterns. An aide doesn't tell a Mexican-American homemaker that tortillas and rice and beans are "wrong foods" or an Indian mother to stop serving her children canned meat and fried bread. Rather, she points out that other foods are also needed and names vegetables and fruits and milk products that the homemaker should have for a balanced diet. In all cases emphasis is on the four basic food groups: milk, meat, vegetables and fruit, and bread and cereals.

The most popular teaching method is the demonstration, usually on a one-to-one basis. After the homemaker has improved her practices, the aide encourages her to move into a group for additional lessons in "food and nutrition." Groups may include as few as two homemakers, but it is not unusual for 10 to crowd into a small kitchen for a demonstration. At group meetings, homemakers share experiences and ideas. Homemakers find food buying, meal planning, and preparation interesting subjects for group meetings.

To achieve her objectives, the aide starts working with families "where they are." She visits homes and instructs homemakers in ways to improve not only food preparation but also meal planning, food selection, and buying. By using simple visual aids such as flip charts, pictures clipped from magazines or posters, or the Phonoviewer, she points out daily nutritional needs. The Phonoviewer is a new inexpensive, easy-to-operate machine. It looks like a small television set and uses a record and a "film key."

The aide at work

Some aides use exhibits and demonstrations to bring their message to homemakers in supermarkets and at community centers where U.S.D.A. Family Food Donations are issued.[1] At one such center in an isolated rural area, the county welfare department used a mobile demonstration unit for a nutrition and food-tasting exhibit. An EFNEP aide manned the exhibit and discussed the program with homemakers, many of whom enrolled in the program.

In Cleveland eight inner city supermarkets let aides set up instore cardtable exhibits on wise food buying. Within a few hours aides talked with more than a thousand shoppers. One attraction was "Food Flashback," a game requiring the player to recall his meals for the preceding 24 hours. It stimulated many questions on nutrition, health, food buying, and food preparation.

Aides in one urban community went from door to door, inviting low income homemakers to attend a demonstration on foods received through the U.S.D.A. Family Food Donation Program. The demonstration included preparing, serving, and eating a meal. Aides gave the women recipes to take home.

The aide's classroom often moves from place to place. As indicated, some States have mobile nutrition demonstration units that can be set up in places homemakers are likely to gather. Sometimes the aide is called a "traveling teacher" for she teaches the homemaker nutrition wherever the time and place permit and with whatever help she can get.

The aides have found that teaching the principles of meal planning not only results in better nutrition but also usually helps the family save money. Homemakers like to report on the savings they make. One told her aide that by applying the aide's lessons she had saved enough in a week to buy sweaters for two of her seven children. And after the aide taught her the nutrient value of orange juice, she began serving her children the juice for breakfast instead of the soft drinks they had been accustomed to.

"Food recalls" for marking progress

Families are not enrolled in the program until specified socioeconomic data have been collected from them. Once the aide has established a working relationship with the homemaker, she gets basic information on her eating habits and on monthly family income and food expenditures. This initial record is basic to the aide's plan for helping each homemaker.

When the homemaker enters the program, the aide asks her to recall all the food she has consumed in the past 24 hours. The aide then records the number of times items from each of the four food groups were consumed during the day. The 24-hour food recall is given every 6 months to evaluate changes in practices.

If the food recall indicates, for example, that the homemaker has not consumed any milk or milk products in the past 24 hours, the aide will discuss the importance of milk (calcium) in the diet and ways of using it in family meals. She may show the homemaker how to prepare a tasty dish with milk or milk products.

Children can be the avenue to getting a family interested in nutrition. One aide, a man specializing in gardening and sanitation, reported that he had been accepted by a family through "first working with the

kids." He had called at one house again and again without being asked in. But some children in the family, after becoming interested in a neighborhood gardening project he was conducting, invited him to their home. The mother's introduction to the children's project proved to be an asset in getting her to enroll in the adult program.

Camps, which are always a popular way to provide a good learning environment, have been used in many States for teaching nutrition. They range from day camps in urban areas to week-long camps in the country where children can enjoy nature while they learn.

Oklahoma held eight camps, averaging 4½ days each, for about 500 boys and girls from EFNEP families. These children not only studied food and nutrition but also learned facts about personal and home sanitation. For most, learning meant fun through creative involvement in games, songs, puppet shows, and skits—centering on nutrition.

In one State children were taught the principles of nutrition at six community centers through hand puppet shows. The simple but clever puppets represented one person showing the effects of good nutrition and another showing the effects of poor nutrition. During the 6-minute presentation, the puppets asked the audience direct questions about food.

After each show the volunteer conducted a brief discussion on nutrition with the children. By the end of the series of classes, the children could categorize foods into various food groups. Often, too, these shows paved the way for aides to be invited into homes where they could interest the mothers in nutrition.

The volunteer's part

Increasingly, Extension aides are able to make their time and ability go further with the help of volunteers drawn from all walks of life. Volunteers who work in the adult phase of the program most often provide the enrolled homemaker with an opportunity to learn about other home economics subjects. Clothing construction is a popular subject, for example.

The volunteer's role includes recruiting and teaching young people, providing transportation for them to participate in county activities, and sometimes acting as baby-sitters while the mothers take part in a nutrition class. In one instance an aide working in an urban area was able to reach nearly 160 girls with nutrition information—by using adult volunteers and 4-H junior leaders. Both the adult and junior leaders were involved in weekly training meetings to prepare them to do a better job of teaching nutrition. As a result, the program gained such acceptance in the housing development that the building management provided meeting facilities.

In Oregon about 400 volunteers worked at U.S.D.A. Family Food Distribution centers in 15 counties, each serving a day or part of a day a month. They were trained and their work coordinated by Extension home economists. Within a year they assisted about 43,000 persons in preparing more nutritious meals from U.S.D.A. donated food items. At Oregon's pay scale for a nutrition aide, the total value of the volunteers' services, based on an 8-hour day, amounted to $7,032 a month.

The youth phase of the program

Although in 1969 a sizable number of young people were involved in EFNEP, Federal legislation for fiscal year 1970 provided for a more nearly concentrated effort to reach young people. As one result, young professional workers were hired to recruit, train, and supervise volunteers to conduct a nutrition program for schoolchildren from low income families.

With the charge to "promote 4-H type programs in the depressed areas of our cities," the general objectives of the young people's EFNEP program are "to educate youth about nutrition, contribute to their personal development through nutrition, and thus improve their families' diets."

Young people are mainly taught in groups, although many are on hand when aides work with their mothers. The professional workers operate through program aides and adult and teenage volunteers to bring a nutrition program to young people. Since July 1, 1970, when reporting on young people's participation began, aides and some 60,000 volunteers have worked with about a million young people. The aide often helps recruit the enrolled homemaker as a volunteer to work with a group of young people in nutrition. The enrolled homemaker's children are particularly encouraged to become group members. The aide may assist in the teaching or she may support the volunteer in her teaching role.

A "junior leader" is usually a teenager who does not assume full responsibility for the group but assists the leader. This position provides the young person with an

opportunity to learn leadership while performing a helpful service.

Extension's part in EFNEP

The Extension Service staff in the U.S. Department of Agriculture has provided national leadership for the EFNEP in the States, just as the State Cooperative Extension staffs have provided leadership for the counties. One of the national office's contributions is the series of six manuals or handbooks on Food and Nutrition Lessons for Training Extension Aides. Another contribution is a film series entitled "Mulligan Stew," developed primarily for 9- to 11-year-olds. A programmed activity book in the form of a comic book reinforces the film content, and provides practice in applying the principles of nutrition introduced in the film.

A new approach growing in popularity is the use of the Phonoviewer, which can be used effectively at small group meetings. The national office has furnished each State one Phonoviewer and notifies States as new film keys and records are developed and offered for purchase.

Many new types of publications are being developed and provided to States and counties such as a comic book presentation of nutrition to children, "Food Facts and Fun With Butter and Boop." A million copies have been made available to State and county Extension staffs through the efforts of the Grocery Manufacturers of America and the Extension Service.

Table 1. Characteristics of homemakers enrolled in EFNEP and those in the program sample

Characteristics	Percentage of EFNEP families in the program[1]	Percentage of families in the sample[2]
Families reporting		
Annual income		
Less than $1,000	19	18
$1,000 - $2,999	46	45
$3,000 and over	35	37
Ethnic group		
White	33	32
Negro	50	52
Spanish-American	15	14
Other	2	2
Residence		
Urban	59	58
Rural nonfarm	32	34
Farm	9	8
Receiving welfare	32	33
Education of homemaker less than 8 years of schooling[3]	32	40
Number of families reporting	*(Number)* 138,666	*(Number)* 10,524

[1] *Calculated from summary reports submitted by all program units participating as of September 1969; does not include families that left the program before September.*

[2] *Sample was selected from all families enrolled before October 1969 and includes families that left the program before that date.*

[3] *About 15 percent of the homemakers in the sample did not report education. The percentage with less than 8 years of education was calculated by dividing the number with less than 8 years by the total number reporting education. In the unit reports the number with less than 8 years was divided by the total number of homemakers in the program. This tends to make the sample percentage larger than the percentage derived from the unit reports. The same procedures were used in calculating the percentage of families on welfare.*

Effects as shown by research

Success stories abound. Drawn from the aides' reports and the observations of county Extension agents, they range from stories about a noticeable reduction in the amount of garbage collected in an area to buying clothing for children with money saved as a result of improved food buying practices. Such reports and observations, of course, are "soft data." To obtain "hard data" on the program's effectiveness, U.S.D.A.'s Economic Research Service conducted a study for the Extension Service 9 months after the program began. Study results indicate that EFNEP is reaching its goal.

The study included a representative sample of about 10,000 families in the program in the fall of 1969. Records were obtained on program families for which two food readings had been taken by the end of September 1969. The 10,000 families selected from 134 sample program units accounted for about 6 percent of all families participating up to that point. It included more than 9,000 families with an initial food reading on the homemaker and nearly 3,000 with two food readings. Families with two food readings had participated in the program for at least 6 months.

The following characteristics of EFNEP families were noted: all had low incomes, most were from minority groups, and most lived in urban areas. The

Table 2. Initial, 6-month, and change in food consumption practices and food knowledge of homemakers by welfare status, 1969[1]

Item	Welfare status					
	On welfare			Not on welfare		
	Food reading		Change	Food reading		Change
	1	2		1	2	
	Homemakers per 100					
Homemakers reporting servings						
Milk group, 2 or more	33	47	14	34	46	12
Meat group, 2 or more	71	81	10	78	85	7
Fruit-vegetable group, 4 or more	13	27	14	15	29	14
Bread-cereal group, 4 or more	37	50	13	37	49	12
1 or more, each food group	54	70	16	57	73	16
2 or more each, milk and meat and 4 or more each, fruit-vegetable and bread-cereal	4	10	6	5	11	6
Homemakers naming as necessary for health						
Milk	74	87	13	79	88	9
Meat	78	91	13	82	91	9
Fruit-vegetable	82	92	10	84	93	9
Bread-cereal	66	78	12	66	77	11
Each of the four food groups	51	68	17	52	69	17
	Dollars					
Average monthly family income and food expenditures						
Income	149	160	11	218	229	11
Food expenditures	58	63	5	77	79	2
Per capita	11.6	12.6	1.0	15.1	15.5	.4
	Percent					
Percentage of income for food expenditures	39	39		35	34	
	Number					
Family size	5.0			5.1		
Homemakers reporting	---	935	---	---	1,804	---

[1] *At least recommended number of servings in each food group.*

average family was larger than the Census Bureau's figures on the size of the average American family: 4.8 persons in contrast to 3.6. There were 10 percent more women than men in the families (table 1).

The average monthly income of families when entering the program was about $221, of which $76, or about a third, was spent on food. Income for a year was less than $2,700 and food expenditures ran about $915. Thus the family spent a large proportion of its income on food, though the actual amount was small. The proportion spent for food reflected income. The families with the lowest incomes spent the highest proportion on food.

About six out of 10 families lived in rented housing. About one out of three was receiving welfare, and more than a third were participating in U.S.D.A.'s Family Food Donation Program or the Food Stamp program.

Most families had the facilities necessary for storing, preparing, and cooking foodstuffs. Only 3 percent did not have electricity, and three out of four had water inside the house (those without water were probably living in rural areas or on farms). More than nine out of 10 had refrigerators and two out of 10 had freezers. Just under 90 percent had stoves and about 60 percent had working ovens.

Table 3. Comparison of nutrition practices of EFNEP homemakers—use of basic four food groups, first and sixth recalls

Number of servings of basic four foods consumed in previous 24 hours	First recall March 1969 (percent)	Sixth recall September 1971 (percent)
Milk		
0 serving	35.1	13.2
1 serving	31.3	26.4
2 servings	20.4	33.5
3 or more servings	13.3	26.8
Meat		
0 serving	7.7	1.6
1 serving	20.5	11.5
2 servings	31.1	30.0
3 or more servings	20.7	56.9
Vegetables and fruit		
0 serving	14.8	2.9
1 serving	27.5	11.2
2 servings	26.8	19.4
3 servings	15.5	20.1
4 servings	9.3	22.5
5 or more servings	6.1	23.9
Bread and cereals		
0 serving	3.8	0.9
1 serving	10.7	3.3
2 servings	21.7	12.2
3 servings	29.7	22.1
4 servings	19.2	30.4
5 or more servings	14.9	31.1

Calculated from 6-month food recall data submitted by all program units participating in the program.

More than seven of 10 homemakers shopped primarily at supermarkets, which means that they had access to a larger variety of foods at lower unit cost than those who shopped at some "corner store." Four out of 10 lived within a mile of their primary shopping outlet, and another four out of 10 within 5 miles. About half used automobiles to get to the shopping outlet, more than 20 percent walked, and the others took taxis or buses or used a combination of transportation methods.

Data for this part of the study were taken for program families during the fall of 1969. About 28 percent of the sample families had left the program, but about 80 percent of those who left had been in the program less than 6 months. Most left because they moved from the area being served by the aide. Only 15 percent left for lack of interest. Some were dropped because they no longer needed the service or had never needed it. But whatever the reason, homemakers seldom left because they did not accept the program. Though families leaving the program and those remaining were usually much alike, those leaving tended to be younger, white, not on welfare, smaller, and with higher incomes. The initial food consumption practices of those leaving were similar to those remaining.

At the time of the original food recall, only about half the homemakers named foods in each of the four basic food groups as being necessary for health, an indication of their lack of knowledge about food and nutrition. Rural, Negro, and more educated homemakers and families in the Food Stamp Program generally had the most information. Higher numbers of homemakers of "welfare families" reported inadequate diets (table 2). The expenditure for food and income of families participating in the Food Stamp or Family Food Donation Program were lower than for families not participating in these programs, but their food practices were about equal to others or, in some cases, superior. Older homemakers knew less about nutrition than younger ones.

Knowledge apparently did make a difference in food purchases. The homemakers who named, for example, fruits and vegetables as necessary to health were also those most likely to be serving these items to their families.

Food recalls taken after 6 months in the program showed substantial improvement in both nutrition knowledge and food consumption practices. Many families were still held back by lack of money, but in many ways the homemakers still improved the family diet. Homemakers of lower income families showed greater gains than the others, and initial differences in consumption practices between the higher and lower income groups lessened.

In the 6 months between the first and second food readings, there was some increase in average monthly income and food expenditures. But the increases were small and largely offset by higher food prices. Changes in income and food expenditures explain very little of the change in consumption of individual food groups.

The intensity of the nutrition education program, as measured by the number of aide visits received by a homemaker over the 6-month period, was found to have a positive effect on diet improvement, particularly in the consumption of milk products and fruits and vegetables. A study of data gathered at the sixth food recall, though not part of the original research, shows even greater changes in the direction of better nutrition (table 3).

The national reporting system gathers data from each unit on a monthly and a 6-month basis for

computation at the Extension Service. These print-out data are used at the State, unit, and national levels as a management instrument.

The Economic Research Service of the U.S. Department of Agriculture is presently contracted to conduct an EFNEP study of the youth phase of the program. Information is needed to respond to widespread public interest in this 4-H type program and to provide a basic evaluation of its success in reaching the young people for whom it is intended.

IN ONLY ABOUT 3½ YEARS, EFNEP has reached more than two million hard-to-reach low income families with information about planning and preparing nutritious meals. Based on the evidence of both "soft" and "hard" data, Extension Service believes that the Expanded Food and Nutrition Education Program is a success. Our confidence in the program stimulates us to even greater effort to make it work. But even more significant, the program has improved the quality of life for these families, and its potential for the future holds even greater promise.

[1] *The Family Food Donation Program distributes a variety of foods donated by the U.S. Department of Agriculture directly to low income families through established distribution centers. The food comes from surplus farm products.*

Neighborhood Service Center

II. *Organizational Structure And Selected Issues*

(Concluded from page 18)

clarify such questions. It may well be that more objective data would contradict the beliefs of administrators, in these areas.

■ Similarly, the perception that administrators hold about the relative strengths and weaknesses of professional and semiprofessional workers should be tested on the basis of more objective criteria. The fact that most adminstrators believe that semiprofessional workers are better able than professional workers to reach persons in need, understand them, and talk to them—even about deeply personal problems—deserves special study. It may be too that such ability and talent as semiprofessional workers bring to bear are much more appropriate for the work that neighborhood centers have carved out and hence much more valuable in the eyes of center administrators. The precise mixing and matching of professional and semiprofessional skills should remain high on research agenda. Their different effect on the persons served must be tested. On the one hand, it matters not at all what administrators believe if the center's users do not agree and objective outcomes do not sustain such beliefs. On the other, to the extent that administrators subscribe to the notion that "believing is seeing," they will begin to act on their beliefs and develop policies and procedures consistent with such beliefs. Time and tide and action wait for no researcher—at least, not for long!

Drug Utilization Review

Improved Patient Care And Cost Reduction

Eleanor Poland

IMPORTANT RESULTS for Medicaid patients—and all medical patients—have come from a research study and demonstration carried out in the Los Angeles County-University of Southern California Medical Center (the LAC-USC Medical Center), from January 1967 to December 1971. The results affected the quality of care, use of the skills of physicians and pharmacists, and the development of methods to control and reduce drug costs. Robert M. Maronde (M.D.) was the project director. He is Professor of Medicine and Pharmacology, University of Southern California School of Medicine. The research received support from the U.S. Department of Health, Education, and Welfare.[1]

The project was set up to develop and test an on-line electronic data-processing (EDP) system of drug utilization review that would improve drug therapy for patients, reduce unnecessary drug costs, and serve as a model for area or regional data banks. The system permits "concurrent review"—that is, review of the patient's drug history on a television screen while he is in the clinic for treatment and before a prescribed drug is dispensed. An off-line system, in contrast, prints out the patient's drug history on paper. Although such histories can be prepared in advance for patients with appointments, the necessary history cannot be retrieved in time for "walk-in" patients. In off-line systems, therefore, the printouts are usually analyzed after the patient has left the clinic, and such analysis is called "retrospective review."

An on-line EDP system is much the more expensive, however. For this reason these questions must be answered before such a system can be adopted. Is it feasible? Is it economically justified? Will patient care be significantly improved? Favorable answers appeared during the study period at the Center.

The LAC-USC Medical Center is one of the largest hospitals in the world. Most of its patients are public welfare and Medicaid recipients. It serves over 200,000 outpatients through more than a million visits a year. And its physicians write between 700,000 and 800,000 prescriptions a year. Studies conducted by the Center's pharmacists show that less than 1 percent of these prescriptions are filled outside the Medical Center.

The EDP system

Through EDP programs and the hardware developed for them, the system can now enter, store, retrieve, and analyze large amounts of data about drug utilization review.[2] When the prescription is presented to the pharmacist for processing, prescription data (physician and patient names, drug and quantity, and instructions to the patient for taking the drug) are entered into the

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system by trained typist-clerks using an abbreviated code form. The computer expands the coded entry and displays it on the terminal screen for corrections, including "automatic legends"—for example, "Shake well," "Refrigerate," and "Discard after 14 days."

When verified, a complete prescription label is printed in the pharmacy. The pharmacist then checks the label against the original order: if it is correct, he dispenses the medication, using the label as a document. In September 1971 the system could store at least 6 months of a patient's prescriptions in the outpatient pharmacies involved in this project. This meant that 60,000 individual patient records were stored and could be retrieved immediately on the television screen for medical analysis. The system can also automatically flag potentially dangerous concurrent prescriptions for an individual patient to alert the pharmacist to review the patient's prescription history with the physician and to discuss the problem with the patient.

Pharmacist and physician

As essential as the EDP equipment to the success of this drug utilization review program is the effective use of skilled members in a health care team. New methods of educating physician and pharmacist and of using their skills have been developed in this project, and rewards in the new system for both made each willing to accept procedural changes.

Because of the pharmacist's key role in the program, the Medical Center's pharmacy staff have been involved in all aspects of program design. Pharmacy clerk-typists have been trained to perform the pharmacy's purely clerical tasks. And the Schools of Medicine and Pharmacy have worked closely in developing a curriculum to graduate a pharmacist who can be a full member of the health care team prepared for carrying out the responsibilities required by the electronic drug utilization program.

Training for pharmacists already working in the hospital included lectures by physicians and clinical pharmacists from the Schools of Medicine and Pharmacy on such subjects as disease processes, therapeutics, and medical semantics and instruction on how to monitor patients for drug effects and how to edit and enter diagnoses and drug orders by computer terminal. The pharmacists so trained were accepted by the clinic physicians in a few weeks as members of the clinic's health team.

Undergraduate curriculum changes in pharmacy education include better instruction in anatomy, histology, pathology, biochemistry, physiology; clinical clerkships in medical settings; and lectures in medicine, therapeutics, and pharmacokinetics given by the Medical School. Junior and senior pharmacy students receive training in the same environment as medical students—on the same wards, with the same patients, and with the same admitting schedules.

The pharmacist so trained can be valuable in drug therapy monitoring. An important reason for following patients in an outpatient setting is to evaluate the effectiveness of therapy, including drug therapy. As an information gatherer, the pharmacist can save time for the physician and can often contribute his special drug knowledge to medical management by interviewing each patient to whom a prescription is dispensed to determine whether he has understood and complied with the physician's instructions and by obtaining answers to such questions as these:

Does the patient have enough (or too much) medication?

Is he getting and using medication about which the clinic has no record?

Is he suffering from side effects or any adverse reaction to the drugs he is taking?

Are there laboratory tests that the physician should order to obtain drug monitoring data?

Will current drug therapy interfere with tests that have been ordered?

Are there physical measurements (pulse rate, blood pressure, respiration) or qualitative evaluations (disappearance rate of a rash, extent of swelling of gums) the pharmacist could take or make that would help evaluate the therapy?

Is the patient abusing drugs?

At the LAC-USC Medical Center, pharmacists are serving as drug information specialists and are monitoring drug therapy because of the EDP system. The physician's education and work have also been influenced by this program. The fact that the pharmacist can show the patient's previous drug history to the physician and raise questions concerning the prescription before it is dispensed introduces a new relationship between physician and pharmacist. Recognition of the contribution to patient care that the pharmacist's drug knowledge can make is strengthened by the special training in medical subjects that the graduate pharmacist is receiving and by the fact that undergraduate

medical and pharmacy students are studying together on the wards.

Standards or definitions

The third essential for effective drug utilization review is the development of standards or definitions for rational prescribing that relate drug usage to diagnosis or therapeutic indication. (A simple example of the need for definition by diagnosis is the difference in amount of aspirin that would be dispensed depending on whether the need was for an occasional headache or for rheumatoid arthritis.) When these definitions include for each drug item in each diagnostic drug list the maximum and minimum daily usage, maximum and minimum duration of therapy, and maximum and minimum amount for an individual prescription, it is possible, by using them in the on-line computer system, to show clearly what is irrational prescribing or what dangerous combinations or amounts of drugs the patient might be obtaining from different clinics and to do this before a new prescription is dispensed. Later analysis of the data by physician and by specific diagnosis and by drug provides information to physicians about rational prescribing. Furthermore, cost figures and data about insurance claims and inventory are natural byproducts of such a system.

The development of definitions for prescribing drugs by diagnosis or therapeutic indication in this project at the LAC-USC Medical Center was made easier by the Center's formulary. (A formulary is a list of the prescription drugs a particular hospital or other medical environment finds the most useful.) The formulary of the LAC-USC Medical Center is made up of about 1,400 drug items (a drug item is a single dosage strength or form of a specific drug; each strength of a drug is considered a separate item), 160 of which account for 90 percent and 868 for 99 percent of all prescriptions.[3]

To arrive at definitions of rational prescribing, the study first defined what was grossly irrational. By studying such computer printouts as all prescriptions by individual drug item, drug quantity dispensed by individual prescription, dosage for individual prescriptions for each drug item, by physician and by patient, it was easy to identify irrational prescribing in three general areas:

Excessive drug quantities by individual prescription.

Excessive frequency of prescriptions for individual drug items.

Inappropriate concurrent prescribing of two or more drug items that if taken together may be harmful.

Furthermore, it was ascertained that less than 3 percent of the prescribing physicians accounted for over 50 percent of the irrational prescribing within the areas defined directly above.

After that, a committee of physicians from the Medical School faculty, aided by pharmacists, defined about 160 of the most frequently prescribed drugs and classified them by pharmaceutical action or indication. Physicians from the faculty representing many specialties and subspecialties were then invited to the committee meetings for the drugs they dealt with most frequently and each definition was reviewed with them and revised as indicated. As Dr. Maronde pointed out, this procedure not only increased the accuracy of the definition, "it also established the basis for peer judgment for any remedial measures that might be used to correct irrational prescribing patterns."

Tabulations of diagnoses and therapeutic indications, when synonyms were eliminated, showed that about 70 diagnoses and therapeutic indications covered over 95 percent of all prescriptions. The high usage drug items were subgrouped in the following lists:

A. Drugs related mainly to organic disease state, excluding infectious disease (such as arteriosclerotic heart disease and pulmonary embolism).

B. Anti-infectious drugs.

C. Gastrointestinal drugs not included in list A.

D. Respiratory and ear, nose, and throat drugs not included in list A.

E. Analgesics.

F. Sedatives, tranquilizers, and antidepressants.

Each drug item was then defined for each appropriate listed diagnosis or therapeutic indication. The maximum and minimum daily dosage, desired duration of therapy, and amount by individual prescription were then specified.

Corrective measures and results

When the three major elements of the program (EDP equipment, pharmacist as drug information specialist, and the development of standards for drug usage related to diagnosis or therapeutic indication) were in operation, remedial measures were applied to three major areas:

Excessive quantities by individual prescription. By having the pa-

tient's record before him, the pharmacist could determine the quantity of medication the patient would require until the next scheduled clinic visit. Even with an extra 2 weeks' supply included, the amount required was almost always less than the physician had requested. The pharmacist modified the quantity, at first, only after discussing the problem with the physician and receiving his permission. At present, however, the physician no longer enters the quantity by prescription; he allows the pharmacist to make this decision. *This procedure resulted in a 5.8 percent decrease in drug quantities dispensed and a similar decrease in drug costs.*

Excessive frequency of prescriptions for dangerous drugs. A dangerous drug list was prepared of those drugs that had the greatest abuse potential. Whenever a prescription for one of these drugs was processed, the patient's prescription file was recalled by the pharmacist and displayed by the computer terminal. The physician was called if the pharmacist believed the prescription frequency was inappropriate, and in almost all instances he agreed with the pharmacist. Although a relatively small number of patients (2.7 percent) were involved, this procedure stopped a dangerous practice—especially in a large hospital where patients see physicians in a number of different clinics and the patient's medical record may not circulate as fast as the patient.

In a special study of dangerous drugs, the pharmacists found that *2.5 percent of dangerous drug prescriptions (0.6 percent of all prescriptions) were filled so frequently that gross abuse by the patient was apparent.* When the physician saw the drug histories in these cases the prescriptions were canceled. These deleted prescriptions accounted for 1.1 percent of the total drug costs.

Inappropriate concurrent prescribing. Definitions of drugs that might have harmful interactions if taken together were compiled for those drugs judged to be the most important and most frequently used. The computer was then programmed to alert the pharmacist when a prescription was processed and a drug defined as having a potentially harmful interaction was in the patient's drug history. The pharmacist then recalled and reviewed the drug history and could recall and review the displayed definitions of interactions. *Over 6 percent of all prescriptions resulted in such computer alerts and about 2.5 percent were deleted after discussion with the physician.* Thus, patient care was improved and the cost savings included the indirect savings due to preventing harmful interaction that might otherwise have resulted in loss of days from work, a hospital stay, or even loss of life.

Findings of the study

Preliminary data available in September 1971 at the LAC-USC Medical Center indicate that significant improvement in cost savings, quality of patient drug therapy, prescribing patterns, and use of the skills of pharmacist and physician can be achieved by using an on-line computer system. This system processes a patient's new prescription and retrieves his prescription history while both he and his physician are near so that remedial action can be taken before the prescription is dispensed.

Cost savings. The cost savings realized by the system can be summarized as follows:

• Excessive quantity single prescriptions	5.8 percent
• Excessive frequency of prescriptions for dangerous drugs	1.1 percent
• Inappropriate concurrent prescribing	4.0 percent
• Voluntary preferential prescribing of A-lac for propoxyphene	3.8 percent
	Total 14.7 percent

And these figures are minimum because not all drugs were studied.

In addition to correcting errors and greatly reducing abuse and fraud, this system can also provide effective assistance in inventory control and producing insurance claims. But an effective cost-benefit study of the system is needed. A plan for such a study was developed during the study period but funds have not yet been made available to carry it out.

Quality of patient care. Improvement in patient care under this system starts with avoiding fragmented treatment because of incomplete records. Often when a patient is treated at different clinics, his medical records do not accompany him from one to the other or, if they do, entries about drugs prescribed may be out of order or hard to find or illegible.

The computer's ability to store, retrieve, and print out for instant display the patient's drug history before the drug is dispensed gives the physician and pharmacist the information they need to provide better drug therapy for the patient. Moreover, by including the phar-

macist as an essential member of the health care team and stressing better professional decisionmaking at the time of patient contact, this project can test, over time, the hypothesis that this system will have an educational effect and, hence, a more nearly permanent effect on prescribing patterns than retrospective "peer" (physician) review of drugs prescribed.

Use of professional skills. Through the EDP system both physician and pharmacist have been spared more routine tasks and can give the time saved to more highly skilled work. The trained pharmacy clerk-typist relieves the pharmacist of routine clerical work; the pharmacist, serving as a drug information specialist, saves the physician's time while making a valuable contribution to patient drug therapy.

Implications

Effective on-line drug utilization review has several potentialities. Not only can it improve patient drug therapy as described, it can also collect drug utilization data as a basis for other studies that can improve patient care and reduce costs. For example, the same data base can serve studies of adverse drug reactions. Hypotheses can be developed and tested through monitoring of adverse drug reactions—especially if there is a network of prescription drug data banks throughout the country.

Such a network of prescription data banks would be needed for proper drug utilization review should there be a national medical insurance program that includes even part payment for all prescription drugs for outpatients as well as inpatients. The Medicaid program, in fiscal year 1971, alone, spent $432 million in Federal and State funds for prescribed drugs for hospital inpatients and $501 million for drugs for outpatients. The Medicare program, which does not cover outpatient prescription drugs, paid $541 million for inpatient drugs alone in the same fiscal year.

Review procedures and insurance claims processing could be coupled if computer capabilities similar to these developed for this project were extended to a network of computers through regions and then nationally. Two major types of computer center programs could be used: prime centers and secondary centers. The patient prescription data bank would be stored in the prime centers; the secondary centers would serve both major dispensing pharmacies, which would be equipped with computer terminals, and smaller outlets with only telephone or off-line data input capabilities.

Would such a program be economically feasible? Dr. Maronde, the project director, believes it would:

During 1970, prescription drugs cost over 8 billion dollars a year. A conservative estimate would be that 10 percent of prescription costs may be saved through the institution of a program of prescription review procedures. A general estimate of the cost of a single data center is that it should not exceed an average cost of 7 million dollars per year, or 0.85 percent of 8 billion dollars. It is further estimated that possibly 30 or 40 data centers should be adequate for nationwide coverage. This network would cost in the neighborhood of 280 million dollars. The savings in drug costs and fraud detection in all probability would exceed this figure. However, the more important gains that are known would be improved patient care and a means of controlling drug abuse.

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[1] *This study began in January 1967 with a 3-year grant (C#0048-01) from the National Institutes of Health, U.S. Department of Health, Education, and Welfare (HEW). It was continued during 1970 and 1971 under two other HEW contracts: OS-07-70-89, which included funds from the Social Security Administration, the Health Services and Mental Health Administration, and the Social and Rehabilitation Service (SRS), and SRS-71-22, an SRS contract only, for the period March 1, 1971, to December 31, 1971.*

These research notes are based on a portion of the final report, prepared during the SRS contract period by Robert F. Maronde (M.D.), project director. The Social Security Administration plans to publish the report, Drug Utilization Review with On-Line Computer Capability—Selected Methodology and Findings from a Demonstration. *Requests for copies should be addressed to T. Donald Rucker, Office of Research and Statistics, Social Security Administration, Washington, D.C. 20201.*

[2] *The EDP equipment in the clinic where patients are seen consists of an IBM 2260 Cathode Ray Tube display station with key-board and a remote printer. These units are attached to a 2848 control machine with buffer storage. The processing unit is an IBM System 360 Model 50 with a 128K memory with one megabyte of bulk core and 12 disk drives. The IBM 2260 is essentially an electric typewriter equipped with a television-type screen to display computer input and message retrieved from the computer storage. The clinic described uses only a small portion of the hospital computer system.*

[3] *A formulary has several advantages for a hospital and an EDP system. Note the following: purchase of prescription drugs can be limited to effective items; a set number of drugs is easier to purchase, store, and inventory than the universe of drugs; a formulary is easier to code, takes less EDP storage, and is easier to maintain and retrieve than the universe of drugs; and rational prescribing is more easily defined for a formulary list of drugs than for the universe of drugs.*

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RESEARCH NOTES

AFDC Mothers: Employed And Not Employed

THOUGH EMPLOYED either full or part time, one in seven AFDC[1] mothers must still depend on public assistance for help, according to a survey made in May 1969 of AFDC families by the National Center for Social Statistics (Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare). The other six in seven are not employed because, principally, of a physical or mental incapacity, no marketable skill or suitable employment, or the need to be home full time (usually to care for young children). In general, the following data concern welfare history and the family and demographic characteristics of AFDC families as they relate to the employment status of the AFDC mother.

AFDC history

The longer the time since the family first received AFDC, the greater the likelihood that the mother is employed. A greater percentage of employed mothers (37 percent) than not employed mothers (33 percent) received public assistance for the first time more than 5 years before the study. (See table 1.)

There is no significant variation between the two groups of women, however, by the length of time since the most recent opening of the case. Though half the employed mothers have received AFDC for 2 or more years, only 48 percent of those not employed have received AFDC that long. About six in 10 of both groups have not previously received AFDC.

A longer period of time since public assistance was first received may allow the AFDC mother to adapt to the conditions that make public assistance necessary and to find other sources of income. Also, employment-oriented services provided with public assistance enable some recipients, over time, to obtain employment and independence.

Family characteristics

Many AFDC mothers are not employed because they are needed in the home to care for their children.[2] However, the average mother, employed or not, has three children (3.1 if employed, 3.0 if not). One in five of the employed mothers, as compared with about one in four of the not employed, has just one child. Proportionately more of the employed mothers than those not employed have more than three children (36 percent and 34 percent, respectively). (See table 2.)

The ages of the children probably have a greater effect on the mother's employment status than the number of children. That a

Table 1. AFDC mothers employed and not employed, by first receipt of AFDC, 1969

First receipt of AFDC	AFDC mother	
	Employed	Not employed
Total number	215,300	1,247,600
	(Percent)	*(Percent)*
1968 - 69	27.9	28.6
1964 - 67	31.8	33.2
Before 1964	36.7	33.2
Unknown	3.5	5.0

Table 2. AFDC mothers employed and not employed, by number of child recipients, 1969

Number of child recipients	AFDC mother	
	Employed	Not employed
Total number	215,300	1,247,600
	(Percent)	*(Percent)*
1 child	20.6	25.2
2 or 3 children	44.0	41.2
4 or 5 children	24.3	21.9
More than 5 children	11.1	11.7

Table 3. AFDC mothers employed and not employed, by status of the father, 1969

Status of the father	AFDC mother	
	Employed	Not employed
Total number	215,300	1,247,600
	(Percent)	*(Percent)*
Dead	4.7	5.5
Incapacitated	7.5	12.3
Unemployed or employed part time	1.4	5.6
Absent from the home		
Divorced	21.3	13.1
Legally separated	3.8	2.9
Separated without court decree	13.1	11.3
Deserted	16.5	15.1
Not married to mother	27.8	28.1
In prison	2.1	2.4
Other reason	0.9	1.2
Other status		
Stepfather case	0.8	2.2
Deprived of mother's support	0.0	0.3

higher proportion of the mothers not employed have only one child could mean that the only child may be very young and, therefore, requires a mother's care. Some of the larger families, undoubtedly, include children old enough to take over some household responsibility, thus freeing the mother for employment.

The employed AFDC mothers are relatively more likely to be heads of households, although the ratio is high for both groups. In many instances the woman heading a household must work because she has the burden of supporting her family in addition to her responsibilities as a mother. Fully 92 percent of the AFDC families with the mother employed, as compared with 82 percent of those with the mother not employed, include only one adult recipient. AFDC families with employed mothers are less likely to include two adult recipients (5 percent and 13 percent, respectively). A small proportion of both groups of mothers who are in the home (both 4 percent) are not AFDC recipients. For example, a mother may be receiving assistance under another program such as the aid to the permanently and totally disabled (APTD).

The status of the AFDC father and his whereabouts are related to the mother's employment status. When the mother is not employed (20 percent), the father is twice as likely to be in the home than when she is (9 percent).

The father is dead in about 5 percent of the families for both groups of women, although the proportion of the employed and the not employed mothers vary when the father is incapacitated or absent from the home. One in 13 of the families in which the mother is employed has an incapacitated father, as compared with one in eight of the families in which she is not employed. Possibly some AFDC mothers may be needed in the home to care for incapacitated husbands, or the family's economic situation, because of unemployment or disability benefits supplemented by public assistance, may be such that it is not necessary for the mother to work.

It is more likely that the couple is divorced or separated or that the husband has deserted when the AFDC mother is employed than when she is not. The parents are divorced in 21 percent of the families with an employed mother and in only 13 percent of the families with a mother not employed. (See table 3.)

The longer the father has been absent because of divorce, separation, or desertion, the more likely it is that the AFDC mother will be employed. A longer absence possibly enables the woman to adjust better to her role as family head and provides sufficient time for her to find employment. She is only half as likely to be employed when the father has been absent for less than 6 years. However, the father's absence exceeds 5 years in four in 10 of the families with the mother employed but in only three in 10 when she is not.

Demographic characteristics

The demographic characteristics reflected in the data concern the AFDC mother's residence, race, age, and education.

Residence. The size of the place where the AFDC mother lives varies considerably, depending on her employment status. Relatively fewer of the employed mothers are living in large metropolitan areas than in small or nonmetropolitan areas. Nearly 40 percent of the mothers not employed live in a city of at least 400,000 population, but only 25 percent of the employed mothers are in a city of this size. Fully 30 percent of the employed mothers and only 24 percent of the mothers not employed live in nonmetropolitan areas.

These variations may be due to the employment situations in different areas of the country as well as to differences between families. For example, the younger AFDC mothers, who are more likely to be not working, are also more likely to live in the larger metropolitan areas.[3] (See table 4.)

Table 4. AFDC mothers employed and not employed, by place of residence, 1969

Residence	AFDC mothers	
	Employed	Not employed
Total number	215,300	1,247,600
	(Percent)	(Percent)
Metropolitan area		
Central city of 400,000 or more	25.1	39.0
Central city less than 400,000	25.8	20.3
Outside central city	18.7	16.3
Nonmetropolitan area	30.3	24.0
Unknown	0.1	0.3

Race. Fully 55 percent of the employed mothers are Negro, as compared with only 41 percent who are white (the remaining 4 percent fall under a category including American Indians, Orientals, and "unknown"). A larger proportion of the employed AFDC mothers are Negro, even though the unemployment rate for Negro women is higher. At the time of the AFDC study, the unemployment rate in the general population was 3.3 percent for white women and nearly twice as high, 6.4 percent, for Negro women.[4] (See table 5.)

Table 5. AFDC mothers employed and not employed, by race, 1969

Race of mother	AFDC mothers	
	Employed	Not employed
Total number	215,300	1,247,600
	(Percent)	(Percent)
White	41.2	51.4
Negro	55.4	44.1
American Indian	0.8	1.3
Other	0.6	0.6
Unknown	2.0	2.6

That a larger proportion of the employed AFDC mothers are Negro may be attributable in part to the higher percentage of Negro AFDC families in the South, where levels of payment standards tend to be relatively low. Fully 64 percent of the AFDC families in the South are Negro, as compared with 44 percent in the Northeast, 51 percent in the North Central region, and 25 percent in the West. Because of the low levels of payment in the South, many AFDC mothers must find employment to supplement their families' assistance payments.

Age. Employed AFDC mothers as a group are usually older than most not employed mothers. The number between 30 and 54 years of age is proportionately higher for the employed than for the not employed: about six in 10 of the employed women in this age group (30-54 years), as compared with five in 10 of the not employed. Very few of the employed (2 percent) and the not employed mothers (3 percent) are over 54 years of age.

Most mothers under 25 years of age have young children to care for, which fact likely precludes their being employed. The need to remain in the home may explain why 26 percent of the mothers not employed are under 25 years of age, as compared with only 16 percent of the employed mothers. Nearly one in five of both groups of women is between 25 and 29 years of age.

Education. Education or training can be of considerable benefit to a person in obtaining a job, including the AFDC mother. However, a relatively high level of education does not necessarily mean the mother will be employed or successful in finding employment. Generally, the employed mothers have more education than those not employed.

[1] *That is, families with the mother in the home receiving public assistance under the aid to families with dependent children program.*

[2] *Recent articles in* Welfare in Review *on the subject of the employability of AFDC women include these: Irene Cox, "The Employment of Mothers as a Means of Family Support," Nov.-Dec. 1970, pp. 9-17; Betty Burnside, "The Employment Potential of AFDC Mothers in Six States," July-Aug. 1971, pp. 16-20; Mildred Rein and Barbara Wishnov, "Patterns of Work and Welfare in AFDC," Nov.-Dec. 1971, pp. 7-12.*

[3] *Unpublished data from the 1969 AFDC Study, National Center for Social Statistics, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare.*

[4] *U.S. Department of Labor, Bureau of Labor Statistics,* Monthly Labor Review, *July 1971, p. 82, 1970 annual average seasonally adjusted.*

The proportion known to have completed at least high school is 1.5 times greater for the employed than for the not employed (33 percent and 22 percent, respectively).

Summary

The characteristics of the employed AFDC mothers, when compared with the not employed mothers, add up as follows:

- They have about the same number of children, although there may be some variation in the ages of the children.
- They are more likely to be heads of households with the primary burden of supporting the family.
- They are less likely to be in a family with the father present. When the father is present, he is less likely to be incapacitated when the mother is employed.
- They usually reside outside large metropolitan areas, possibly because of fewer employment opportunities in such areas and differences in family composition.
- They are more likely to be Negro than white or another race, even though the unemployment rate is higher for Negro women in the general population.
- They are generally older and, therefore, more likely to have children not needing close supervision or children who are able to care for younger children in the family.
- They are more likely to have completed high school than mothers who are not employed.

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Measures Of AFDC Family Size

A LITTLE NOTED QUIRK of statistical methodology has resulted in the overstatement of the number of children in the "typical" family receiving public assistance. As a consequence, a small, repeated inflating of family size has occurred that tends to reinforce the stereotype of large-sized "welfare families." This has come about where the computed number of children in the average family must be expressed in fractions of a child. I will describe several possible alternative methods and apply each to the data for the aid to families with dependent children program (AFDC) and show how this overstatement could be corrected.

As applied to AFDC, the term "family" is plastic, capable of being applied simultaneously to completely different groupings of related persons. Because the membership of the family can vary broadly, statistical measures of AFDC families lean more toward the general than toward the specific. Even so, the term "family" as used in AFDC seems to be understood wherever used. Unfortunately, what is understood is sometimes irrelevant to the discussion at hand. For example, as used in the administration of the State-Federal program, the concept of "family" is theoretically based on statutory language in the Social Security Act but in practice is largely based on statistical tabulations of program operations data. In other words, the abstract becomes concrete: the data have shaped the concept of the AFDC family.

Briefly, AFDC makes money payments to persons in need through a system of grants-in-aid to the States to conduct programs of assistance to families with dependent children. At the close of fiscal year 1971 (June 30, 1971), there were 2,747,000 families receiving AFDC. They include 7,429,000 recipient children and 2,795,000 recipient adults.[1]

The Social Security Act defines "dependent child" in Sec. 406 (a) to mean a "needy child (1) who has been deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, and who is living with his father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepsister, uncle, aunt, first cousin, nephew, or niece, in a place of residence maintained by one or more of such relatives as his or their own home, and (2) who is (A) under the age of eighteen or (B) under the age of twenty-one and (as determined by the State in accordance with standards prescribed by the Secretary) a student regularly attending a school, college, or university, or regularly attending a course of vocational or technical training designed to fit him for gainful employment."

Even though the AFDC family may consist of a child or children living with any of the specified (caretaker) relatives, most AFDC families are one-parent and that parent is the mother. There were, as

of January 1971, for example, about 326,000 AFDC families (17 percent) in which there were two parents present in the home. Thus the concept of "family" as used in AFDC differs markedly from the concept of the two-parent family for both size and social-economic function.

Source of data—surveys

National AFDC surveys have been carried out by the U.S. Department of Health, Education, and Welfare (HEW) and its predecessor agency, the Federal Security Agency, periodically since 1942. The most recent survey, conducted in February 1971 (of families receiving public assistance in January 1971), contains data closely paralleling data collected in similar surveys in 1969, 1967, and 1961.

In these studies the concept of "family" is not an issue and is loosely defined as synonomous with "assistance unit" or "assistance group." The survey unit is comprised of AFDC recipients, that is, the persons whose needs are included in the unit for which a budgeted monthly amount is computed. The "assistance group" might live with other related persons (not included in the grant because they are receiving other kinds of assistance or are not "in need"). Or it may live in a household with unrelated persons. A third of the families live in households with persons who are not members of the assistance group.

The AFDC survey "family" is in many instances not a "family" in the social sense but a payment unit. Children live with their mother, their father, with both parents, or with neither parent but with other relatives. All these patterns are termed "families" in the program. The assistance group can be broadly categorized as adults and children who are tabulated in AFDC studies, as shown in table 1.

Table 1. AFDC recipients in 1971, 1969, 1967, and 1961, as categorized in Federal data

Recipients	1971[1]	1969[2]	1967[3]	1961[4]
Assistance groups	2,523,900	1,630,500	1,278,222	822,700
Adults	2,598,900	1,669,000	1,320,448	733,700
Children	7,014,700	3,939,704	3,940,162	2,665,619

[1] *U.S. Department of Health, Education, and Welfare, National Center for Social Statistics,* Findings of the 1971 AFDC Study: Part I, Demographic and Program Characteristics *(Washington: The Center), 1971.*

[2] *U.S. Department of Health, Education, and Welfare, National Center for Social Statistics,* Findings of the 1969 AFDC Study: Data by Census Division and Selected States, Part I, Demographic and Program Characteristics *(Washington: The Center), Dec. 1970.*

[3] *U.S. Department of Health, Education, and Welfare, National Center for Social Statistics,* Findings of the 1967 AFDC Study: Data by State and Census Division, Part I, Demographic and Program Characteristics *(Washington: The Center), July 1970.*

[4] *U.S. Department of Health, Education, and Welfare,* Study of Recipients of Aid to Families with Dependent Children, November 1961, National Cross-Tabulation *(Washington: Welfare Administration), Aug. 1965.*

Paralleling these survey data are comparable data reported monthly from State operations, as shown in table 2. The differences between the two sets of data are attributable to both survey sampling error and to unadjusted over- and underpay-

Table 2. AFDC recipients for selected months in 1961, 1967, 1969, and 1971, as categorized in State program data

Month	Year	Number of recipient families	Number of recipient children
June	1961	877,961	[1] 2,612,611
December	1967	1,297,000	[2] 3,986,000
May	1969	1,652,000	[3] 4,870,000
January	1971	2,634,000	[4] 7,224,000

[1] *U.S. Department of Health, Education, and Welfare,* Annual Report, 1962 *(Washington: The Department), 1962.*

[2] *U.S. Department of Health, Education, and Welfare, National Center for Social Statistics,* Advance Release of Statistics on Public Assistance *(Washington: The Center), 1967.*

[3] *U.S. Department of Health, Education, and Welfare, National Center for Social Statistics,* Public Assistance Statistics, May 1969 *(Washington: The Center).*

[4] *U.S. Department of Health, Education, and Welfare, National Center for Social Statistics,* Public Assistance Statistics, Feb. 1971 *(Washington: The Center).*

ments reported by the States for a given month that are normally adjusted later.

Summary data—arithmetic mean

Because the AFDC family has the particular characteristics of being headed mostly by women, what summary statistics would best describe these "families"? The average number of child recipients in each family is one traditional measure. But based on monthly operational data, only the arithmetic mean of all units can be calculated. To illustrate:

Arithmetic mean number of child recipients per AFDC family

1971	2.7
1969	3.0
1967	3.1
1961	3.0

The arithmetic mean, of course, is useful as a ready comparison of this characteristic of "families" in the caseload over time, but it does not delineate the composition of welfare families. As mentioned, the total number of families included a substantial number in which there are only child recipients; hence, the term "family" cannot be applied to these cases in the ordinary sense. In addition, the mean can be distorted by values at the extremes of the range. Thus we have an index that is sound enough as a figure but that reveals little about the essential qualities of the "families."

The median

What about the median? To arrive at the median, we must use AFDC tabulations of families by number of children. The number of children in the median family (all survey units) for each of the survey years is as follows:

Year	Children
1971	2.8
1969	3.0
1967	3.2
1961	3.1

As noted, the distribution of values for total families would include so-called recipient families for which there were adult recipients in the assistance group. The number of children in the median family including one adult recipient for each of the four years is as follows:

Year	Children
1971	2.8
1969	3.0
1967	3.2
1961	3.3

For families with two adult recipients, figures for these years are as follows:

Year	Children
1971	3.5
1969	3.9
1967	4.1
1961	No such cases payable under law applicable in 1961

Though it is often chosen as the summary figure closest to expressing the idea of "most typical" or representative, the median does not truly carry such meaning. It merely indicates, in an array, the value of the item below and above which are an equal number of items. Nevertheless, the minor statistical convention of describing family populations by the number of children in the median family is sufficiently well established for it to normally go unquestioned. Nothing better seems to be at hand. However, trying to sum up the composition of the public assistance family, the over-simplification that is inherent in the use of the "median family" has perhaps contributed to misunderstandings regarding AFDC family size.

The usual focus on the number of children in the typical AFDC family often carries the overtones of attitudes expressed in this once popular assessment of the plight of the poor: "The rich get richer and the poor get children." The median as a measure directs attention away from the fact that 54 percent of assistance units headed by a single adult, as shown in the tabulations below, did not have 2.8 children in 1971 but one child or two children.

Number of children in AFDC families with one adult recipient

Number of children	Percent
1	29.1
2	25.2
3	18.6
4	11.9
5	7.0
6	4.1
7 or more	4.2

Note that though the computation of the mean is performed by simply dividing the total number of children by the total number of families, computation of the median involves arbitrary methodology for the assignment of values that lie between the one-child category and the two-child category.

Medians with noncontinuous data

HEW data have been based on the following assumption of values in an array of discrete values:

Number of children

Value	Range
1	1.0-1.9
2	2.0-2.9
3	3.0-3.9
4	4.0-4.9
5	5.0-5.9
And so on	. . .

Table 3. Percent distribution of single adult recipient families by number of children, for studies conducted in 1961, 1967, 1969, and 1971, and alternative medians

Year	Number of children										
	1	2	3	4	5	6	7	8 or more	Md_1	Md_2	Md_3
1971	29.1	25.2	18.6	11.9	7.0	4.1	2.2	2.0	2.8	2.3	1.8
1969	25.9	23.8	18.3	13.4	8.3	4.8	2.9	2.6	3.0	2.5	2.0
1967	23.8	23.1	18.9	13.9	9.1	5.5	3.0	2.6	3.2	2.7	2.2
1961	22.4	22.1	19.7	15.4	9.0	5.5	3.1	2.7	3.3	2.8	2.3

Md_1 = U.S. Department of Health, Education, and Welfare

Md_2 = Mueller, Schuessler, and Costner method

Md_3 = Platky proposal

Source: See footnotes 1, 2, 3, and 4, table 1, page 62

This has the effect of assigning the median value of 2.8 to the 1971 distribution in which the median falls within the two-child category.

As an example of a standard textbook methodology, Mueller, Schuessler, and Costner[2] recommend the following assumption of value for such discrete data arrays:

Number of children

Value	Range
1	.5-1.5
2	1.5-2.5
3	2.5-3.5
4	3.5-4.5
5	4.5-5.5
And so on	---

The values are one-half integer lower at any given level; therefore, the HEW median of 2.8 becomes 2.3. The selection of the midpoint is, in effect, a rounding operation of all fractional values within the single interval value.

The percent distributions of number of children in one-adult families for each of the study years and the median as computed under each of the above assumptions are presented in table 3.

A third possible arbitrary assignment of values can be made as follows:

Number of children

Value	Range
1	0-1.0
2	1.0-2.0
3	2.0-3.0
4	3.0-4.0
5	4.0-5.0
And so on	---

The rationale here is simply that no higher whole integer "label" would be ascribed to a lesser value. There is also a stronger sense of "orderly progression" to begin a value series at 0. Moreover, this method is the only one in which, for example, the 1969 data conform to the common-sense view of the problem. In another array of values, however, this method has the disadvantage of lacking symmetry, that is, the median would not be the same if computed from either the upper or lower end of the series. The HEW method also has this failing.

Conclusions

Historically, the "typical" AFDC family has been described as a mother and three children. This is based on the median appearing under Md_1 in table 3 (although HEW medians for family usually include all types of units, those without adults not excepted). Under this alternative the median, say for 1969, has the value of 3.0, although one- and two-children families comprise 49.7 percent of the distribution. An additional .3 percent does not change the value of the median. Even though AFDC

[1] *National Center for Social Statistics, U.S. Department of Health, Education, and Welfare,* Public Assistance Statistics, June 1971, *Report A-2 (6/71) (Washington: The Center), 1971.*

[2] *John H. Mueller, Karl F. Schuessler, and Herbert L. Costner,* Statistical Reasoning in Sociology *(New York: Houghton Mifflin Co.), 1970, pp. 41-42, 125-26.*

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families are almost precisely divided into groups with no more than two children or with three or more, the median is stated as three.

THE STATISTICAL CONVENTIONS surrounding the method of computation of the median for size of family appear, in sum, to have resulted in overstatement of the size of the "typical welfare family" by 33 percent. The typical welfare family of a mother and three children is a statistical artifact—she has but two.

LEON D. PLATKY

Training Programs For Vietnam Era Veterans

ONE OF THE MOST DISHEARTENING national problems of recent years is the economic dislocation of Vietnam veterans, as their high unemployment rates make manifest. Nearly a million servicemen left the Armed Forces during 1971, raising to 5.6 million the number of veterans who have served in the Vietnam era (a Vietnam era veteran is a person who served in the Armed Forces after August 1964). About 80 percent of these men were 20 to 29 years old, and their youth is important in understanding their unemployment problems.[1]

An average of 3.9 million veterans ages 20 to 29 were in the labor force during the fourth quarter of 1971—a half million more than during the fourth quarter of 1970.[2] The unemployment rate for veterans in this age bracket was 7.8 percent in the fourth quarter of 1971, the lowest quarterly rate of the year. The highest 1971 unemployment rate was during the first quarter: 10.8 percent, or 3 percent higher than in the previous quarter.[3] In the second and third quarters of 1971, the unemployment rate for veterans 20 to 29 years old fell to 8.5 and 8.3 percent.[4]

Throughout 1971 the unemployment rate of veterans 20 to 29 years of age was higher than unemployment rates for nonveterans in the same age group. In the third quarter, for example, the unemployment rate of nonveterans in this age bracket was 6.9 percent, or 1.4 percent below the rate for veterans. During the fourth quarter, the rate for nonveterans remained at 6.9 percent, but the unemployment rate for veterans dropped to 7.8 percent, leaving a gap of less than 1 percent. In the last 3 months of 1971, about 304,000 veterans were looking for jobs.[5]

Negro veterans have an especially hard time finding work. The unemployment rate for Negro veterans 20 to 29 years of age is much higher than for white veterans. In the third quarter of 1971, the jobless rate for Negro veterans was 14 percent, as compared to 7.7 percent for white veterans. During the fourth quarter, the unemployment rate was 13.8 percent for Negro veterans and 7.1 percent for white veterans, a difference of 6.7 percent.[6]

The younger the veteran the more severe the problem of finding a job. The 1971 quarterly unemployment rate for veterans 20 to 24 years of age was consistently higher than for veterans 25 to 29 years of age. In the third quarter the younger veterans had an unemployment rate of 11.2 percent, as compared to a 5.8 percent rate for veterans 25 and over. The unemployment rate for veterans 20 to 24 during the fourth quarter of 1971 was 11 percent, more than twice the 5.1 percent rate for the older veteran.[7]

As a result of the high unemployment rates for Vietnam era veterans, several programs have been established by the Federal Government directed toward them. Three such programs are discussed in these Research Notes.

One is Project Transition, administered by the U.S. Department of Defense, for servicemen who are soon to be released from the Armed Forces and who are in need of vocational training or education to adjust to civilian life. During fiscal year 1971, about 50,000 servicemen received training through the project. Between 17 and 19 percent of the trainees were Negro.[8] First consideration for training is given to veterans who are combat-disabled or ineligible for reenlistment; who entered the service without a skill and did not acquire one in the service that could be used in civilian life; or who need refresher courses in the occupations followed in civilian life before entering the service.

Project Transition aims at training men who are still in the service for occupations for which there are shortages in the geographic area to which they are planning to return. The facilities of the U.S. Department of Labor and State and local employment agencies are used to

make job opportunities known to servicemen before they leave the Armed Forces and in placing them in jobs afterwards.[9]

The second program incorporates this import benefit: *the right of reemployment.* Veterans who left jobs to enter the Armed Forces (whether they enlisted or were drafted) are eligible for reemployment rights and a program to ensure that they obtain their rights is administered by the Office of Veterans' Reemployment Rights, U.S. Department of Labor. The veteran must have left a job (other than temporary) to enter the military, served no longer than 4 years (not including voluntary extensions up to 1 year or any involuntary extensions), and be capable of holding the job.[10] The employer is required to rehire the eligible veteran in his old job or one similar to it with the same status, seniority, rate of pay, and fringe benefits as though he had never left.[11]

Although it is not known how many veterans sought their old preservice jobs, there were about 6,900 cases during fiscal year 1971 in which the Office of Veterans' Reemployment Rights was asked to intervene to secure reemployment rights for veterans.[12] Most cases did not involve the basic right to reemployment. Rather, they were concerned with pay rates, promotions, and fringe benefits.[13]

Another program for veterans is the Veterans Educational Assistance program (the GI Bill), administered by the Veterans Administration. This program provides assistance to veterans to continue their academic education or to take vocational and technical training courses. During fiscal year 1971, more than 1.1 million Vietnam era veterans were receiving educational training through the GI Bill. Over 700,000 were attending college; almost 17,000 were in high school; about 58,000 were taking post-high-school vocational and technical training; and about 195,000 were taking other vocational and technical instruction. Of the college students, about 357,000 were undergraduates, a little over 86,000 were in graduate school, and about 258,000 were in junior college.[14]

Veterans taking any type of full-time educational training under the GI Bill receive monthly benefits from the Veterans Administration according to the number of dependents: $175 if they are single, $205 if they have one dependent, $230 if they have two, and $13 per month more for each additional dependent.[15]

The effectiveness of these programs, however, has not been fully measured. If we are to serve veterans to the extent of their need, we must have answers to such questions as these:

–What proportion of veterans returning from Vietnam participate in training or readjustment programs?

–What is the ethnicity of those who do participate?

–What kinds of jobs do veterans get after leaving the training programs? How long do they keep them?

–What is their income level after leaving a training program?

–If they were employed before entering the service, how does their present income compare with their preservice income?

–What proportion drop out before finishing a course? Why? What happens to those who drop out, as compared to those who remain?

ANSWERS TO QUESTIONS like these should be helpful in the evaluation of these programs and make them more effective in achieving their goal: to help veterans overcome barriers to their employment through education and training.

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[1] *U.S. Department of Labor, Bureau of Labor Statistics, "Employment Situation of Vietnam Era Veterans: Fourth Quarter 1971 and Annual Summary," News Release, Jan. 17, 1972, p. 2.*

[2] *Ibid., pp. 1, 4. The data used here are quarterly averages. They are not seasonally adjusted and are subject to sampling variability.*

[3] *The unemployment rate for veterans rose in the first quarter of 1971 because of a seasonal pattern observed over the past 3 or 4 years. Statement of Elizabeth Waldman, U.S. Department of Labor, Bureau of Labor Statistics, Feb. 22, 1972; also see U.S. Department of Labor, Bureau of Labor Statistics,* Employment and Earnings *(Washington: U.S. Government Printing Office), Jan. 1972, p. 166.*

[4] Employment and Earnings, *op. cit.*

[5] *Ibid.*

[6] *Ibid. Data for Negro veterans are based on small sample numbers and are subject to large sampling errors. Thus their unemployment problems can be discussed generally only.*

[7] *Ibid., pp. 167-68. It is difficult enough for veterans with honorable discharges to find jobs; those with dishonorable discharges find it very much more difficult if not almost impossible.*

[8] *Statement of Mark Colburn, U.S. Department of Defense, Office of Manpower and Reserve Affairs, Feb. 10, 1972, and Apr. 11, 1972.*

[9] *Elizabeth Waldman and Katheryn R. Gover, "Employment Situation of Vietnam Era Veterans,"* Monthly Labor Review, *Sept. 1971, p. 8.*

[10] *Ibid.; also see U.S. Department of Labor, Labor-Management Services Administration,* Veterans Reemployment Rights Handbook *(Washington: U.S. Government Printing Office), 1970, pp. 20-22.*

[11] *Handbook, op. cit., p. 45.*

[12] *Waldman and Gover, op. cit., p. 8.*

[13] *Ibid., p. 9.*

[14] *Veterans Administration,* Veterans Benefits Under Current Educational Programs, *Information Bulletin DVBIB 24-71-8 (Sept. 8, 1971), pp. 1, 19.*

[15] *Statement of an official of the Veterans Administration, Mar. 17, 1972.*

BOOK NOTES

Public Health And One State's Government

Public Health and the State: Changing Views in Massachusetts, 1842-1936, by Barbara Gutman Rosenkrantz (Cambridge: Harvard University Press), 1972, 259 pp., $9.

AS THE TITLE IMPLIES, this is a book about changing relationships between the public health movement and the State government of Massachusetts. The author is particularly interested in the methods that public health people use to try to get the State to take responsibility for certain aspects of public health and in the assumptions about public health that these people made. At the beginning of the period (1842) and, indeed, as early as colonial times, a major method of promoting public health measures was moral suasion. If certain epidemics arose from rotting vegetation, they could be prevented by cleaning up garbage in the streets. People were urged to keep their neighborhoods clean. This approach to public health was no more successful with the State's poverty-stricken population than it was with the rich industrialists along the Merrimac River who were dumping sewage and factory wastes into the river.

At the middle of the century, Lemuel Shattuck, an eminent reformer, believed that morbidity and mortality statistics should serve as the groundwork for involving government in public health. By comparing statistics in different towns, it should be possible to show that mortality and morbidity rates differed. He also believed that the reasons for these differences could be modified by government intervention. Shattuck had the correct approach: one must clearly establish reasons before one can persuade legislatures to put money into public health.

The discovery of the bacterial causes of cholera, typhoid, tuberculosis, and the other major infectious diseases was a powerful tool in involving the State in public health. With the help of sanitary engineers, it was possible to trace epidemics directly to polluted water supplies. But even a scientific basis for action did not convince the men in power. A pseudoscientific theory at the time was that streams purified themselves of bacterial and chemical contamination after they had flowed several miles below the source of contamination. It was hard to dislodge such widely accepted folklore by scientific demonstrations, particularly when it was to the advantage of the large industrial manufacturers that the belief remain prevalent.

By the end of World War I, the Massachusetts Department of Health had clearly demonstrated the effectiveness of public health measures in prophylactic immunization. The great success of these measures defined the health department's role so clearly that further development to meet new situations was blocked. During the early 20th century, the belief that education might help prevent alcoholism, drug addiction, venereal disease, and pollution was popular, but it is really only in the last decade that high schools have started programs to instruct the young about sexuality, drug addiction, alcoholism, venereal disease, and the effects of cigarette smoking. (It is interesting that many of these programs meet opposition even today.)

In 1910 only one degenerative disease was listed in the first five causes of death in Massachusetts. But 20 years later pneumonia was the sole contagious disease still on the list. Degenerative diseases had displaced almost all infectious diseases because of the successful control of the latter. Thus, by the end of World War I, the major health problem was no longer the infectious but the degenerative and social diseases. Yet the Massachusetts Department of Public Health was loathe to take on new problems. Indeed, in 1926 it disclaimed social problems originating in society or resulting from chronic disease.

However, its attitude did change. Rosenkrantz identifies the acceptance of responsibility for social reform by the health department as the major characteristic of the new public health ideology. It was perhaps best expressed in 1936 by Dr. Wade Hampton Frost of Johns Hopkins: "Activities directed purposefully toward the promotion of health cannot be separated, except in an artificial way, from the whole mass of human activities." Thus Rosenkrantz brings us to the beginning of the public health movement in 1936. She is complete master of

the ideas and literature of the period and presents them interestingly.

Public Health and the State goes far beyond a mere recitation of the changing methods and assumptions of the health movement and their acceptance. In her epilogue Rosenkrantz points out that the success of sanitary reform depends on the receptive temper of the community. Beyond this there are the philosophical questions of how much responsibility the government has to regulate individual and corporate behavior and which threats to a harmonious life require government intervention. These questions are just as potent today as they were during the last century. "The development of state responsibility for public health has, therefore, faced a dual task of establishing objectives which meshed concepts of general welfare with specific definitions of health; and of elaborating methods to achieve goals consonant with acceptable social and scientific precepts. Within this context, the effectiveness of antidotes to disease and disorder has been largely measured by the expectation and satisfaction of reformers."

Two important questions should be asked about works in social history. The first is whether the methodology is appropriate to the task set by the author and whether the available methods of research in social history limit the significance and importance of the questions posed. Perhaps the title and subtitles give some insight into this problem of social historians. The first part of the book's title *Public Health and the State*, conjures up a vision of an ordering of the relationships at all levels between public health and government. This would include discussions of all the problems the author recognizes as of first importance such as what actually was the "receptive temper" of the community, how far is the government justified in limiting individual freedom for public health purposes, and how the public health movement reaches consensus in its aims and judges its accomplishment. The answers to these questions are really not available in any kind of reliable data so that the author is actually forced into discussing "changing views in Massachusetts." These views are those put forward by such well-known public figures as Lemuel Shattuck, Jacob Bigelow, Edward Jarvis, Henry Ingersoll Bowditch, Richard Frothingham, Henry Pickering Walcott, and Theobold Smith.

The views of the State are indirectly revealed in the action taken by the legislature. The needs of the industrial establishment and the party in power generally were more important in determining public health legislature than genuine social needs. An occasional governor took forthright leadership, but in general the State as represented by the legislature was indifferent to public health needs.

The first question leads to a second. "What can we learn of the potential of the future from the heritage of the past?" Several generalizations are helpful as an agenda toward future action in public health: the aims of public health are defined largely by reformers. To me this suggests that the impetus for growth of public health is in the hands of prophets rather than scientists or priests. Nevertheless, the results of future programs must be justified by the scientific method. Second, programs must have the possibility of success. Public health concerned with immunization was relatively successful. The new public health, concerned with all the major social problems of chronic disease, old age, alcoholism, drugs, and pollution, will have more trouble getting government support. Public health programs tend, except during emergencies, to be less appealing to voters and legislatures than new stadiums for the local professional gladiators, new highways for the industrial complex, and financial renovation of central cities.

The "receptive temper of the community" is the most important influence in determining the outcome of public health efforts. New ideas, new goals, new efforts emerge with relative frequency. It is on the rock of community temper that most of these plans flounder. Thus we need to know more about

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what influences the "receptive temper of the community"—how it may be changed, led, involved.

In brief, although the author would like to write about public health and the State, she is forced by historical circumstances to present the "dialogue" between reformers and legislative committees. Social historians are forced to deal with what is available in the records. Such material is seldom as definitive as we would like.

THIS STUDY is not only of importance to persons interested professionally in the place of government in the maintenance of public health, it is also of interest to the general reader who wishes to comprehend the problems encountered when people with new ideas come up against entrenched bureaucracy, whether it be city, State, or the Federal government; medical professionalism; political patronage; or industrial disregard for public well being. Its message is to the moment: in fact, many of the problems (of which water pollution is a major illustration) are with us as much today as they were a hundred years ago. The difference is that now the forces aligned against improvement are stronger.

DOUGLAS CARROLL

Clarifying the Need for Change

Systematic Thinking for Social Action, *by Alice M. Rivlin (Washington: The Brookings Institution), 1971, 150 pp., $5.95. (Gaither Lectures, delivered January 1970, at the University of California, Berkeley, under the sponsorship of the Graduate School of Business Administration and the Center for Research in Management Science.)*

IN THIS BEAUTIFULLY and lucidly written volume, Alice Rivlin raises some of the most important questions about social problems and social action facing government decisionmakers. The right answers to these questions would require a thorough assessment of our social needs and an equitable allocation of our resources to meet these needs within a hierarchy of social priorities. The right answers would also give us performance measures to indicate which solution would be most effective and most efficient.

Systematic Thinking for Social Action is a collection of lectures in a continuation of a series addressed to the general problem of how to make government decisions more rationally. Dr. Rivlin focuses on two issues. First, she analyzes the social services programs of special current concern in the social action areas of education, health, manpower training, and income maintenance that are designed to help individual people and families function better. Her second focus is on the new techniques used in government to evaluate such programs: PPBS, systems analysis, and systematic social experimentation. In her tightly reasoned essays, she, as it were, evaluates the "evaluators," and gives a "mid-term report card on the contributions of analysis to decisions concerning social action."

Alice Rivlin is singularly competent to do what she sets out to do. As Assistant Secretary for Planning and Evaluation in the Department of Health, Education, and Welfare during the Johnson Administration, she faced head-on the problems of identifying social needs and of evaluating the performance of government programs. This position involved tackling the most critical problem of all: comparing alternative methods of delivering services to identify those methods that appeared to be most cost-effective. Her pithy chapter titles indicate the tack she is taking: "Who Wins and Who Loses?" "What Does the Most Good?" "What Do We Know?" "Can We Find Out What Works?" "Accountability: What Does It Mean?"

Four basic propositions, put in the form of questions, are the theme of her book:

> How should the problems be defined? Who are the people for whom specific social action programs are intended and how much more are they helped?
>
> Which programs are most effective and how do the benefits of alternative programs compare?
>
> How can better social services be produced?

She considers the first two propositions as positive in that considerable progress has been made in identifying and measuring social problems and thus clarifying policy choices. Moreover, systematic analysis has improved knowledge of how initial costs and benefits of programs are interrelated and should be distributed. For example: policy about the program to be selected for social welfare reform must be based on realistic assessments of what is fiscally and politically feasible. Children's allowances, therefore, had to be ruled

out. Budget constraints also ruled out a negative income tax with a guarantee at or near the poverty line. Though a negative income tax plan with a fairly low level would be sufficient, some families would be worse off than under existing State welfare plans. Two plans, therefore, had to be merged: the first, the Federal cash guarantee to families; the other, a reimbursement or subsidy guarantee to the States so that they could maintain their current welfare payment levels at no additional cost to them. The plan finally adopted by the Nixon Administration includes both these features plus coverage of working poor families and strong work incentives. But the details of its impact on families and on States still needs to be studied, and this analysis continues to this day in the form of income maintenance experiments. The role of analytical work is especially important in determining the outcomes under alternative versions of the Family Assistance Plan concerning the distribution of benefits and whether and how patterns of living and working of family members would change.

According to Dr. Rivlin, only systematic social experimentation will yield answers to questions, whether we are talking about supporting income maintenance plans or plans for higher education or for health services or for manpower training.

Dr. Rivlin's third and fourth propositions turn to lacunae in our knowledge: she says that little has been done in comparing the benefits of different programs and, more importantly, little is known about how more effective health, education, and other social services could be produced or how people would respond to them. Nor does she find such programs organized to let us find out.

One dilemma for the Federal Government manager who designs social action programs that Dr. Rivlin does not mention is inherent in the political system. As long as authority for Federal programs is vested in different congressional committees with different goals, emphases and philosophies and different ideas as to performance effectiveness and evaluation measures, the relative merit of one program as against another can only be established with great difficulty. It may be that systematic planning for and coordination of social action programs calls for equal planning and coordination in the Congress.

Because different social action programs benefit different people and because the programs produce both private and public benefits, it is particularly difficult to compare the benefits of the programs in commensurable terms. Public benefits are especially hard to identify and measure.

The concept of the accountability of participants in social action programs receives special mention. Dr. Rivlin insists that improvement in the effectiveness of services provided is not enough unless the producers of these services are held responsible to the communities and the taxpayers they serve.

To improve social service delivery, Dr. Rivlin cautions that the social analyst must give high priority to developing and refining measures of performance suitable for judging and rewarding effectiveness. But he must avoid single measures of social service performance and his measures must reflect the difficulty of the problem. She concludes: "To do better, we must have a way of distinguishing better from worse."

ALICE RIVLIN'S CONTRIBUTION to modern social thought leaves a powerful impression. Her book brilliantly performs the important function of clarifying the need for a drastic change in the method in which we attack social problems and pointing out the direction in which this change has to move. We must hope that she will continue her inquiry into the role of government in social action with the logic and clarity with which she has illuminated the problems.

Studies Of Cash Transfer Proposals

Poverty Policy—A Compendium of Cash Transfer Proposals, *Theodore R. Marmon, ed. (Chicago, New York: Aldine-Atherton, Inc.)* (Social Research and Public Policy, *a series edited by Lee Rainwater, Harvard University), 1971, 241 pp., $8.50 clothbound, $4.95 paperback.*

POVERTY POLICY is a collection of previously published essays and reports on poverty and welfare policy. These essays, well-known in the fields they address, provide the full range of proposals for welfare reform that were publicly and privately debated in the 1960's and that finally culminated in President Nixon's welfare reform bill, H.R. 1. Though experts of many different convictions labored to arrive at equitable concepts that once trans-

lated into programs would solve the seemingly intractable problem of poverty in this country or at least alleviate it in a humane and rational way, legislators are now working on the final formulation—compromising as they must between ambitious attempts to stamp out poverty and the reluctance of hard-pressed State governments and disillusioned taxpayers to allocate ever-greater funds for poverty and welfare programs.

This book serves to remind us that poverty has many facets, that a welfare system can only partly reduce the hardships of many different population groups and lift the intolerable burden of a survival existence. We have already discovered that efforts to deal successfully with these problems are extraordinarily difficult. With sensitivity and wisdom, the editor has selected from a vast literature outstanding papers on proposed antipoverty, welfare reform, and tax equity measures.

This compendium should be of special interest to students of social welfare theory and practice and to Government planners and policymakers concerned with bringing the American underclass to a level of decent living and as far as possible into the mainstream of economic life. The many alternative methods for attacking poverty presented in *Poverty Policy* make it possible to reassess what needs to be done and how it might be done.

Part I of the four parts into which the editor divides the collection gives the dimensions of the prospects for reduction of poverty and the concepts, criteria, and comparisons of various possible income maintenance systems, as analyzed by the editor. Part II contains summaries of the various welfare proposals advanced in recent years, from that of the Advisory Council on Public Welfare in 1966 to President Nixon's Family Assistance Act of 1969. Robert Lampman's early formulation of a Negative Income Tax Plan is included, as is Alvin Schorr's children's allowances program. Part III contains summaries of such antipoverty programs as Edward Schwartz's Family Security Program, Harvey Brazer's analysis of Tax Policy and Children's Allowances, the *Yale Law Journal's* Model Negative Income Tax Statute, and the Heineman Commission's *Report on Income Maintenance Programs.* Part IV, concerned with tax equity in income distribution, contains Earl Rolph's article on a credit income tax and Joseph Pechman's on tax policies for the 1970's.

From a historical perspective, these discussions of welfare reform and of antipoverty proposals are particularly helpful because of their focus on the difficulties inherent in developing programs politically capable of overcoming public and congressional distaste for an expensive but much needed system that would not only reduce welfare caseloads but make substantial inroads in reducing poverty.

Many of the welfare reform proposals discussed represent the deep concern of social workers and welfare administrators for a more effective system, a system capable of meeting adequately the economic needs of welfare recipients, eliminating the geographical inequities of different State eligibility and financial standards, eradicating the stigma associated with welfare, concentrating benefit payments among the most needy, and reforming welfare administration. Many of the persons making these proposals examined formulas for work incentive and for including some of the working poor. They were, however, less likely to worry about the political realities of obtaining more liberal legislation, nor were they much troubled about program costs.

It was the antipoverty writers with the goal of reducing poverty in general and not just improving the lot of welfare recipients who unflinchingly recommended programs looking both ways. They wanted programs that not only would guarantee income maintenance levels moving toward or at the poverty standard of the Social Security Administration. They would also include the "nonpoor" in such schemes as universal children's allowances, disregarding the realistic cost constraints and with an illusory conception of the progressivity of the Federal personal income tax system.

It is perhaps too easy to criticize these proposals from today's vantage point. It has become painfully clear from continuing public debates that cost constraints are equally as important as social justice. It must also be said, in defense of these earlier writers, that they could not foresee the great recent rise in the numbers of AFDC recipients, nor the increasing gap between welfare payments and the consumer price index of the last 3 years, nor the rising and crushing burden on the treasuries of States and their political subdivisions. Though the number of poor persons has steadily declined over the last 7 years, the dimensions of poverty for those who are poor have not lessened.

But these early plans are important. That many of them influenced the drafters of President Nixon's welfare reform bill will be seen from a comparison of chapters 3 and 4. Recommendations made in the form of "Basic Social Guaran-

tees" by the Advisory Council on Public Welfare in "Having the Power, We Have the Duty" (chapter 3) and become part of the Family Assistance Act of 1969 (chapter 4) and H.R. 1, the latest version of welfare reform, now being debated in the Congress.

An important theoretical concept on which the President's bill is based is a model of the Negative Income Tax (NIT). Beginning with its early formulation by Lampman (chapter 5) and adapted for administrative implementation by Speth, Cotton, Bell, and Mindus in an article in the *Yale Law Journal* (chapter 9), the NIT model has been much refined in recent years and the rendition on which H.R. 1's two family plans are based is more elaborate than those presented here.

The strong NIT work incentives built into the President's bill and found in the Yale Law School model are also part of the Heineman Report model (chapter 10), signifying general agreement among economists on how an income maintenance system could be structured. All these plans stipulate universal eligibility, national administration, a schedule of marginal tax rates, and a relatively impersonal administration.

Because of the NIT's relationship to the positive tax system, it is not surprising that tax experts have looked into the issue of reducing poverty using a NIT system combined with a plan for reforming the tax structure. Rolph's proposal for a credit income tax (chapter 11) and Pechman's recommendations for changes in the State, local, and Federal tax structure (chapter 12) represent two different designs with the double purpose of alleviating poverty and making the tax system more nearly equitable. According to Rolph's radical "credit income tax" plan, all deductions in the Federal personal income tax would be removed and all income would be subjected to a proportional tax of 24 to 30 percent, in an effort to improve welfare, reduce poverty, and make the tax system fairer to taxpayers.

Pechman, to meet the costs of a rapidly rising demand for public services at all levels, would shift the tax burden from low and middle income taxpayers to those in upper income brackets by eliminating the special tax benefits to the wealthy such as provisions for capital gains, interest on State-local bonds, income splitting, and other tax shelters. In addition, he would adopt a NIT plan to attack the poverty problem directly.

SIGNIFICANTLY, the Tax Reform Act of 1970 has moved in the general direction of these plans and public discussion is continuing on ways to relieve the tax burden on low income groups and to increase it for better off taxpayers. Some of Pechman's recommendations concerning changes in the standard deduction and exemption have now become law, but many others requiring a more radical structural reform to close tax loopholes of wealthy taxpayers and concentrate tax benefits in the lower part of the income scale still await action. It is important to have these ideas again brought to public attention in *Poverty Policy.*

HELEN O. NICOL

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National Center for Social Statistics

Applications, cases approved, and cases discontinued for public assistance, April-June 1971. Report A-9 (4/6/71), 5 pp. text and 7 tables. Presents data on the numbers of applications received, pending, and disposed of and on cases approved for public assistance, April-June 1971.

Child care arrangements of AFDC recipients under the work incentive program as of the last day of the quarter ended June 30, 1971. Report E-4 (6/30/71), 4 pp. text and 3 tables. Presents data on child care arrangements for children receiving AFDC whose mothers were enrolled in the Work Incentive Program (WIN) on June 30, 1971, and on the number of mothers who could not be referred to WIN because such care was not available.

Children served by public welfare agencies and voluntary child welfare agencies and institutions, March 1970. Report E-9 (3/70), 4 pp. text and 13 tables. Reports on the living arrangements for children in the programs of aid to families with dependent children and child welfare services.

Numbers of recipients and amounts of payments under medicaid and other medical programs financed from public assistance funds, 1969. Report B-4 (CY 69), 7 pp. text and 35 tables. Presents data on the number of recipients, distributed by basis of eligibility, for 1968 and 1969, and the percentage change between the 2 years.

Public assistance statistics, November 1971. Report A-2 (11/71), 2 pp. text and 14 tables. Presents data on services provided to public assistance recipients in Nov. 1971.

Public assistance statistics, December 1971. Report A-2 (12/71), 3 pp. text and 14 tables. Presents data on services provided to public assistance recipients in Dec. 1971.

Reasons for discontinuing money payments to public assistance cases, January-March 1971. Report A-11 (1/3/71), 5 tables. Presents data on number of cases for which money payments were discontinued during Jan.-Mar. 1971.

Reasons for disposition of applications other than by approval, April-June 1971. Report A-10 (4/6/71), 2 pp. text and 4 tables. Presents data on reasons for disposition of applications other than by approval during Apr.-June 1971.

Rehabilitation Services Administration

Characteristics of clients rehabilitated in fiscal years 1966-1970. Publication No. (SRS) 72-25402, 1972, 38 pp. Contains data on the socioeconomic and program characteristics of persons rehabilitated during 1966-1970.

State vocational rehabilitation agency: program data: fiscal year 1971. Publication No. (SRS) 72-25016, 1972, 100 pp. Presents data on program progress for fiscal year 1971.

Youth Development and Delinquency Prevention Administration

Juvenile Delinquency Prevention and Control Act of 1968. Publication No. (SRS) 72-26005, 1972, 88 pp. Summarizes grants for planning and implementing programs of prevention and rehabilitation of delinquents for fiscal year 1971.

Legislative guide for drafting State-local programs on juvenile delinquency. Publication No. (SRS) 72-260, 1972, 40 pp. Provides suggestions for the development of legislation for programs of delinquency prevention and treatment administered by State and local agencies.

SOCIAL SECURITY ADMINISTRATION

Office of Research and Statistics

An analysis of State variations in black lung allowance rates, by John M. Little and Lawrence D. Haber, Division of Disability Studies. Apr. 20, 1972, Note No. 8, 4 pp. and 5 tables. Reviews the Social Security Administration's experience in making disability determinations on applications for black-lung benefits.

Economic resources of institutionalized adults, by Philip Frohlich. Apr. 1972, Report No. 3, 25 pp. Summarizes information on the economic resources of institutionalized adults including employment experience, income, and assets.

The effect of changing technology on hospital costs, by Saul Waldman, Division of Health Insurance Studies. Feb. 28, 1972, Note No. 4, 4 pp. text and 2 tables. Studies the rise in hospital cost by comparing the increases attributable to the rise in cost to the increases necessary to maintain a hospital service at a certain level.

Extended unemployment compensation: early experience, by Sophie R. Dales, Division of Economic and Long-Range Studies. Mar. 31, 1972, Note No. 7, 3 pp. text and 2 tables. Presents data on accounts transferred from extended unemployment compensation to the State.

Maximum benefits under the Social Security Amendments of 1971, by Alfred M. Skolnik and Jane Ceccarelli, Division of Economic and Long-Range Studies. Apr. 27, 1972, Note No. 9, 4 pp. text and 3 tables. Discusses the conditions under which the new maximum benefits are payable and also the relationship of family benefits to individual benefits and covered wages.

Medical care price changes 1967-1971, by Loucele A. Horowitz, Division of Health Insurance Studies. Mar. 24, 1972, Note No. 6, 8 pp. text and 4 tables. Summarizes price changes for medical care.

Social security numbers issued, 1937-71, by Herbert R. Tacker, Division of Statistics. May 8, 1972, Note No. 10, 3 pp. text and 3 tables. Lists data on social security numbers issued, 1937-71.

NON-GOVERNMENT

The allergic child, by Kjell Aas. Translated from the Norwegian by Lizann Disch. Charles C. Thomas Publisher (301 Lawrence Ave., Springfield, Ill. 62703), 1971, 287 pp., $11.95. Presents information directed at families who have children suffering from allergies.

American Indians and Federal aid, by Alan L. Sorkin. Brookings Institution (1775 Massachusetts Ave., N.W., Washington, D.C. 20036), 1971, 231 pp., $7.50. Describes and assesses Federal assistance programs in health, education, welfare, property income management, and manpower development.

Business in the humane society, by John J. Corson. McGraw-Hill Book Co. (330 W. 42d St., New York, N.Y. 10036), 1971, 314 pp., $12.50. Discusses how economic and social trends are forcing business to serve the public interest, thereby insuring itself added strength, greater profit, and leadership.

Community organization and social planning, by Robert Perlman and Arnold Gurin. Council on Social Work Education (345 E. 46th St., New York, N.Y. 10017), 1972, 292 pp., $8.95. Reviews and examines social planning in community organization.

Day care: how to plan, develop, and operate a day care center, by E. Belle Evans and others. Beacon Press (25 Beacon St., Boston, Mass. 02108), 1971, 337 pp., $6.95. Presents information and advice on planning, developing, and operating a day care center for preschool children.

The effect of three income maintenance programs on work effort, by Alfred and Dorothy Tella. A report prepared for the Chamber of Commerce of the United States of America. The Chamber (1615 H St., N.W., Washington, D.C. 20006), 1971, 33 pp., $2. Discusses the effects of three negative income tax plans with various guarantee levels, tax rates, and cutoffs on the annual hours of men and women heading households.

The forgotten American—American Indians remembered, compiled by Jere L. Brennan. Council on Social Work Education (345 E. 46th St., New York, N.Y. 10017), 1972, $3. Serves as resource material for persons who want a better understanding of the American Indian and the forces affecting his life.

Handbook of child nursing care, by Margaret Ann Wallace. John Wiley and Sons, Inc. (605 3d Ave., New York, N.Y. 10016), 1971, 138 pp., $4.50. Discusses the nursing procedures and situations the pediatric nurse most frequently meets.

Imitation in children, by Paul Guillaume. Translated by Elaine P. Halperin with a foreword by Bernard Kaplan. University of Chicago Press (58th St. at Ellis Ave., Chicago, Ill., 60627), 1971, 214 pp., $11.50. Presents a theory of the role of imitation in the learning of children from birth to the 3d year based on detailed observation of the author's children.

Management and the health services, A. Gatherer and M. D. Warren, eds. Pergamon Press (Maxwell House, Park Fairview, Elmsford, N.Y. 10523), 1971, 175 pp., $8. Discusses England's National Health Service relating to decisionmaking, statistics in the management of health and welfare services, evaluation of services, operational research, and so forth.

Marijuana and personality change, by Jess R. Lord. Heath Lexington Books (125 Spring St., Lexington, Mass. 02173), 1971, 124 pp., $12.50. Reports on a study using the Minnesota Multiphasic Personality Inventory to determine what changes take place after smoking marijuana once.

The Mississippi experience: strategies for welfare rights action, Paul A. Kurzman, ed. Association Press (291 Broadway, New York, N.Y. 10007), 1971, 189 pp., $5.95. Presents a report of eight community organizers—both Negro and white—who worked as volunteers with the Community Development Agency in Hinds County, Miss.

Poverty in Canada, John Harp and John R. Hofley, eds. Prentice-Hall of Canada (1870 Birchmount Rd., Scarborough 707 Canada), 1971, 357 pp., $4.94). Discusses Canadian studies on poverty within a sociological perspective.

Readings in social psychology, Jonathan L. Freedman, J. Merrill Carlsmith, and others, eds. Prentice-Hall (Englewood Cliffs, N.J. 07632), 1971, 573 pp., $6.95. Designed to accompany a textbook for and introductory course in social psychology; contains 42 articles in its field.

Reforming the poor: welfare policy, federalism, and morality, by Joel F. Handler. Basic Books, Inc. (404 Park Ave., So., New York, N.Y. 10016), 1972, 168 pp., $5.95. Discusses President Nixon's Family Assistance Program and what will happen if the plan is adopted or rejected by the Congress.

Resources in social change: race in the United States, by James S. Coleman. John W. Wiley & Sons (605 3d Ave., New York, N.Y. 10016), 1971, 119 pp., $7.95. Describes the process of gaining resources among Negroes in the United States.

Students at a disadvantage in higher education, by Nora Holland. Council on Social Work Education (345 E. 46th St., New York, N.Y. 10017), 1972, 72 pp., $3. Explores issues involved in developing programs for educationally disadvantaged students in social work education.

Therapeutic consultations in child psychiatry, by Donald Woods Winnicott. Basic Books, Inc. (404 Park Ave., So., New York, N.Y. 10016), 1971, 410 pp., $15. Contains a series of 21 therapeutic consultations by a noted psychoanalyst on successful methods of treating children.

Up against the urban wall, Ted Venetoulis and Ward Eisenhauer, eds. Prentice-Hall (Englewood Cliffs, N.J. 07632), 1971, 546 pp., $9.95. Gives opinions and theories about the disastrous state of urban society as related to city life, crime, politics, race, economics, and so forth.

What's so special about teenagers? By Child Welfare League of America, Inc. (67 Irving Pl., New York, N.Y. 10003), 1972, 42 pp., $2. Discusses the problems of teenagers in foster care.

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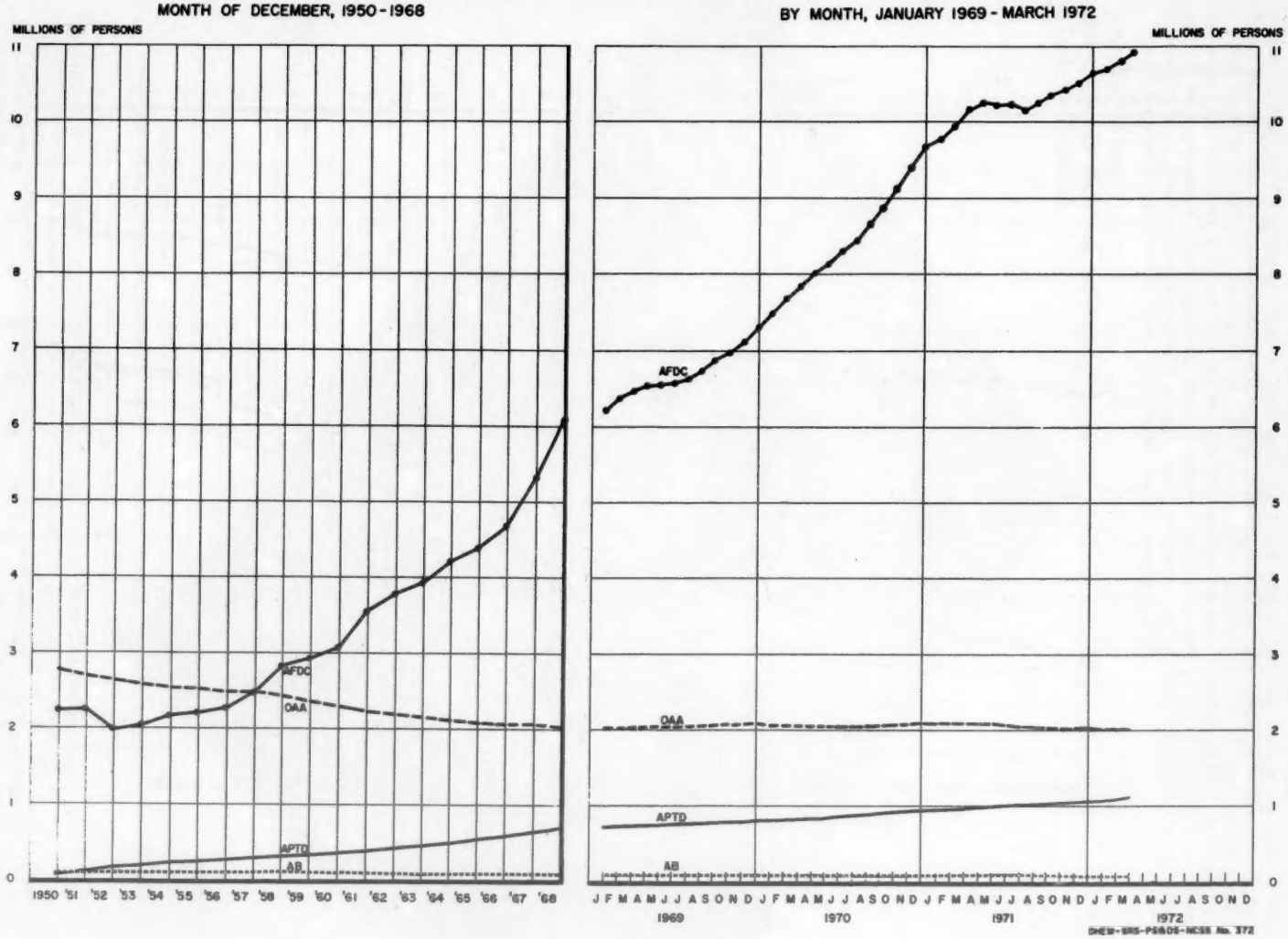

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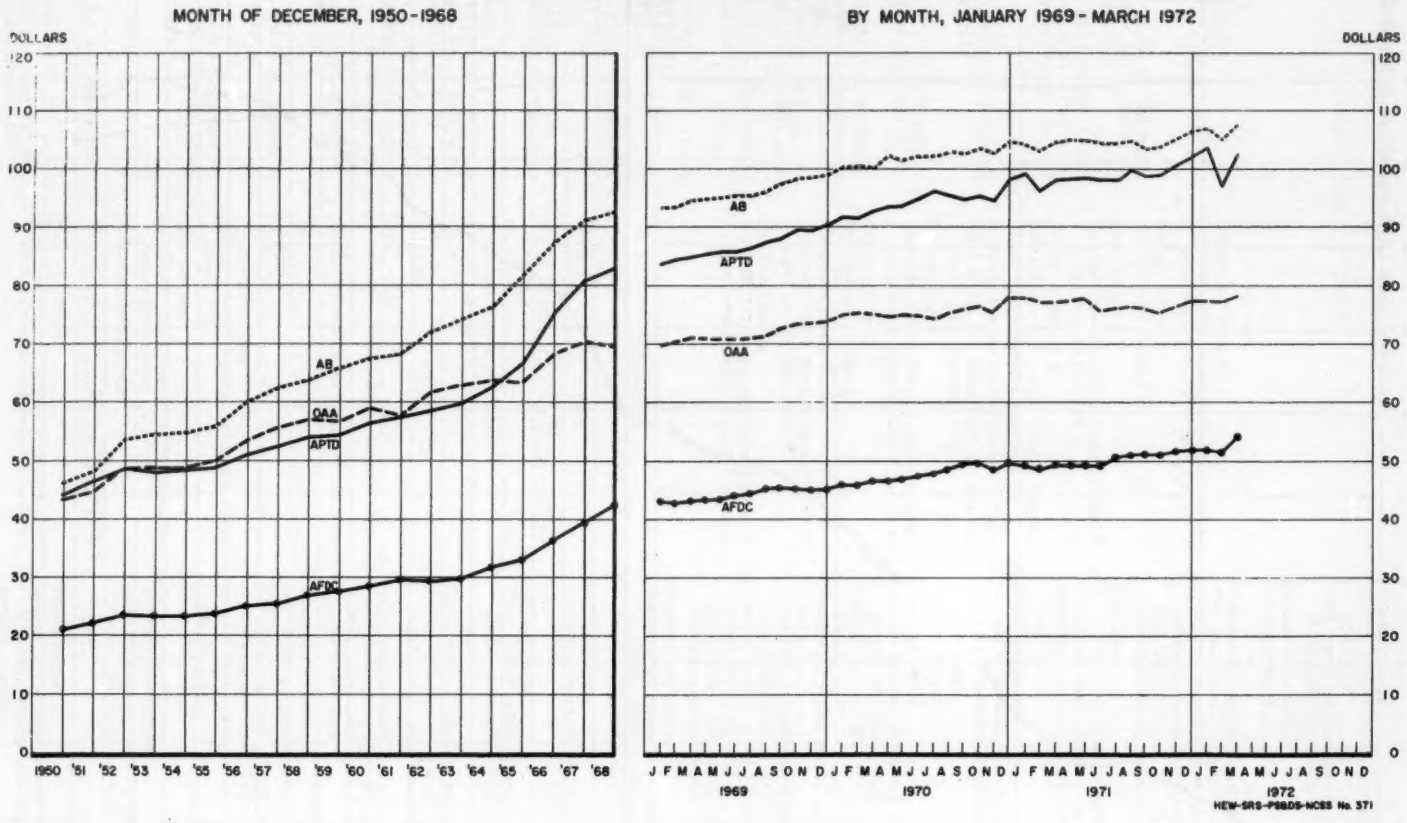

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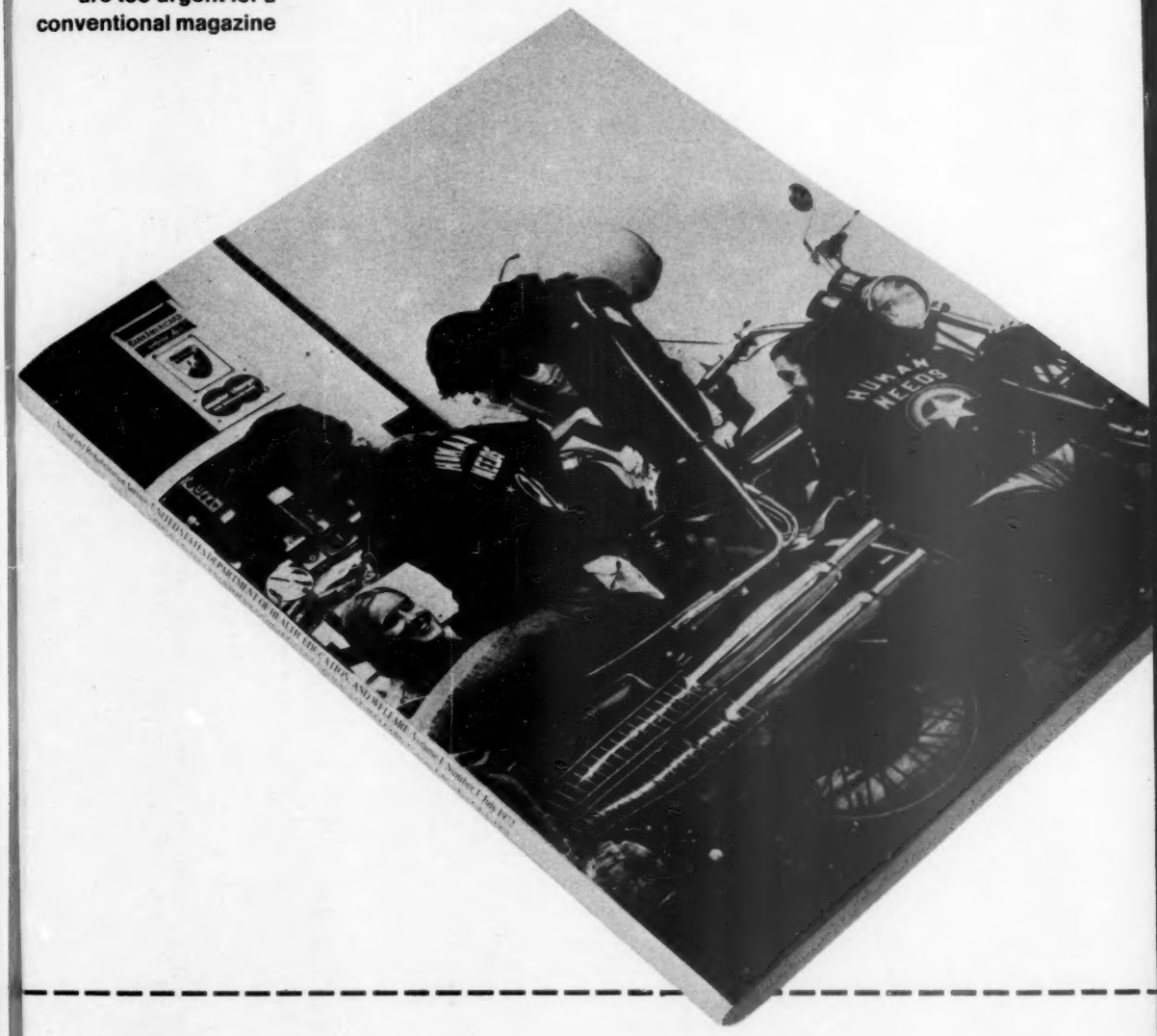

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